

No. 88-1377-CFX Title: Louis W. Sullivan, Secretary of Health and Human
Status: GRANTED Services, Petitioner
v.
Brian Zebley, et al.

ocketed:

February 15, 1989 Court: United States Court of Appeals
for the Third Circuit

Counsel for petitioner: Solicitor General

Counsel for respondent: Kauffman, Mark, Stein, Jonathan M.

Entry	Date	Note	Proceedings and Orders
1	Jan 6 1989	G	Application (A88-540) to extend the time to file a petition for a writ of certiorari from January 16, 1989 to February 15, 1989, submitted to Justice Brennan.
2	Jan 9 1989		Application (A88-540) granted by Justice Brennan extending the time to file until February 15, 1989.
3	Feb 15 1989	G	Petition for writ of certiorari filed.
5	Mar 9 1989		Order extending time to file brief of respondent on the merits until April 24, 1989.
6	Apr 20 1989		Brief of respondents Brian Zebley, et al. in opposition filed.
7	Apr 20 1989	G	Motion of respondent Joseph Love, Jr. for leave to proceed in forma pauperis filed.
8	Apr 26 1989		DISTRIBUTED. May 11, 1989
9	May 5 1989	X	Reply brief of petitioner filed.
10	May 15 1989		Motion of respondent Joseph Love, Jr. for leave to proceed in forma pauperis GRANTED.
11	May 15 1989		Petition GRANTED. *****
13	Jun 28 1989		Order extending time to file brief of petitioner on the merits until July 10, 1989.
15	Jul 10 1989		Joint appendix filed.
14	Jul 11 1989		Brief of petitioner Louis Sullivan filed.
17	Jul 27 1989		Order extending time to file brief of respondent on the merits until September 11, 1989.
18	Aug 24 1989		Record filed. * 6 vol., USCA 3
19	Sep 8 1989		Brief amici curiae of National Easter Seal Society, et al. filed.
20	Sep 9 1989		Brief amici curiae of Pennsylvania Protection and Advocacy, et al. filed.
21	Sep 11 1989		Record filed. * Certified original record, box, received.
22	Sep 11 1989		Brief amici curiae of American Medical Association, et al. filed.
23	Sep 11 1989		Brief amici curiae of Medical Issues Task Force of United Handicapped Fed., et al. filed.
24	Sep 11 1989		Brief amici curiae of American Academy of Child and Adolescent Psychiatry, et al. filed.
25	Sep 11 1989		Lodging received. (20 copies).
26	Sep 11 1989		Brief amicus curiae of Natl. Organization Social Security Claimants' Representatives filed.

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Entry	Date	Note	Proceedings and Orders
27	Sep 11 1989		Brief amici curiae of Massachusetts, et al. filed.
28	Sep 11 1989		Brief amici curiae of Children's Defense Fund, et al. filed.
29	Sep 11 1989		Brief of respondents Brian Zebley, et al. filed.
30	Sep 26 1989		SET FOR ARGUMENT TUESDAY, NOVEMBER 28, 1989. (1ST CASE)
31	Sep 29 1989		CIRCULATED.
32	Oct 11 1989	G	Application (A89-272) to extend the time to file a reply brief from October 11, 1989 to October 20, 1989, submitted to Justice Brennan.
33	Oct 11 1989		Application (A89-272) granted by Justice Brennan extending the time to file until October 20, 1989.
34	Oct 20 1989	X	Reply brief of petitioner United States filed.
35	Oct 21 1989		Lodging received.
36	Nov 7 1989		Supplemental brief of respondents Brian Zebley, et al. filed.
37	Nov 22 1989	X	Supplemental brief of petitioner Sullivan, Sec., H&HS filed.
38	Nov 24 1989		Lodging received.
40	Nov 27 1989	X	Supplemental brief of respondents Brian Zebley, et al. (SECOND SUPPLEMENTAL BRIEF) filed.
39	Nov 28 1989		ARGUED.

88-1377

No.

Supreme Court, U.S.

FILED

FEB 15 1989

JOSEPH P. SPANIOLO, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1988

**DON M. NEWMAN, ACTING SECRETARY OF HEALTH AND
HUMAN SERVICES, PETITIONER**

v.

BRIAN ZEBLEY, ET AL.

**PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

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QUESTION PRESENTED

Whether Social Security disability regulations that base the determination whether a child is disabled exclusively on medical factors without also considering vocational factors used for adults are inconsistent with 42 U.S.C. 1382c(a)(3)(A), which provides that a child under the age of 18 shall be considered disabled if he suffers from "any medically determinable physical or mental impairment of comparable severity" to one that would entitle an adult to benefits.

II

PARTIES TO THE PROCEEDING

Petitioner is the Acting Secretary of Health and Human Services. The respondents are plaintiff Brian Zebley and intervenors Evelyn Raushi and Joseph Love, Jr., representing a class, certified by the district court, of "[a]ll persons who are now, or who in the future will be, entitled to an administrative determination (whether initially, on reconsideration or on reopening) as to whether supplemental security income benefits are payable on account of a child who is disabled" (App., *infra*, 6a).

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In the Supreme Court of the United States

OCTOBER TERM, 1988

No.

DON M. NEWMAN, ACTING SECRETARY OF HEALTH AND
HUMAN SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

The Solicitor General, on behalf of the Acting Secretary of Health and Human Services, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-20a) is reported at 855 F.2d 67. The memorandum and order of the district court (App., *infra*, 21a-24a) are reported at 642 F. Supp. 220.

JURISDICTION

The judgment of the court of appeals was entered on August 10, 1988. A petition for rehearing with suggestion for rehearing *en banc* was denied on October 18, 1988. App., *infra*, 25a. On January 9, 1989, Justice Brennan extended the time for filing a petition for a writ of certiorari

to and including February 15, 1989. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. 1382c(a)(3)(A) provides in pertinent part:

An individual shall be considered to be disabled * * * if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

42 U.S.C. 1382c(a)(3)(B) provides in pertinent part:

For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy * * *.

20 C.F.R. 416.924 provides:

We will find that a child under age 18 is disabled if he or she —

- (a) Is not doing any substantial gainful activity; and
- (b) Has a medically determinable physical or mental impairment(s) which compares in severity to any impairment(s) which would make an adult (a person age 18 or over) disabled. This requirement will be met when the impairment(s) —

- (1) Meets the duration requirement; and
- (2) Is listed in Appendix 1 of Subpart P of Part 404 of this chapter; or
- (3) Is determined by us to be medically equal to an impairment listed in Appendix 1 of Subpart P of this chapter.

STATEMENT

1. Supplemental Security Income (SSI) is available to certain persons who are "disabled." An adult is disabled if he or she "is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. 1382c(a)(3)(A). A child under 18 is disabled "if he suffers from any medically determinable physical or mental impairment of comparable severity." *Ibid.* (emphasis added).

The Secretary has developed a five-part test to determine whether an adult filing a claim for benefits is disabled.¹ This test gives an adult three basic ways to show

¹ The five-step evaluation is set forth at 20 C.F.R. 416.920. See *Bowen v. Yuckert*, No. 85-1409 (June 8, 1987). Step one determines whether the claimant is engaged in "substantial gainful activity." If so, benefits are denied. If the claimant is not engaged in such activity, the decisionmaker goes to step two, which asks whether the claimant's impairment or combination of impairments is "severe." If not, benefits are denied. Step three requires a determination whether the impairment is the same as or equivalent to a listed impairment. If so, the claimant is presumed disabled. At step four, the inquiry is whether the impairment prevents the claimant from doing his relevant past work. If the claimant cannot perform his relevant past work, the evaluation proceeds to step five, which decides whether the claimant can perform other work in the national economy in light of his age, education and work experience.

disability. First, if the claimant can show that he suffers from one of the "listed impairments" set forth in the regulations, with associated clinical symptoms and a specified degree of severity, he is presumed disabled. 20 C.F.R. 416.920(d), 416.925.² Second, a claimant who can show the "medical equivalent" of a listed impairment also benefits from a presumption of disability. 20 C.F.R. 416.920(d), 416.926. Finally, if the claimant has neither a listed impairment nor its medical equivalent, the Secretary will examine his "residual functional capacity" to determine if the claimant can perform his relevant past work or—given the claimant's age, education and work experience—whether he can perform other work in the national economy. 20 C.F.R. 416.920(e) & (f), 416.945.

Children are evaluated on a slightly different standard. Like adults, children must not be engaged in substantial gainful activity and must suffer from an impairment likely to last at least 12 consecutive months. 20 C.F.R. 416.924. In addition, a child is presumed disabled if he suffers from one of the listed impairments used for adults, to the extent that "the disease processes have a similar effect on adults and younger persons." 20 C.F.R. 416.924(b)(2), 416.925(b). Children can also show the medical equivalent of one of the listed impairments. 20 C.F.R. 416.924(b)(2); 416.925(b). Unlike adults, however, children are not evaluated on the basis of their capacity to perform prior work or substantial gainful employment in the national economy. Instead, children are covered by an additional list of impairments beyond that provided for adults and may establish the existence of one of these impairments or its medical equivalent. Thus, the regulations provide a

² The listed impairments appear in Appendix 1 to 20 C.F.R. Part 404, subpart P.

two-part list of impairments. Part A applies to adults and children alike, while Part B applies to children under 18 alone. 20 C.F.R. 416.925(b).

2. Brian Zebley suffers from congenital brain damage with spastic right hemiparesis, mental retardation, developmental delay, eye problems and musculoskeletal impairments on the right side (App., *infra*, 5a). He received SSI disability benefits from age two for a little over 28 months. In 1982, his benefits were terminated on the grounds that the then-current medical evidence demonstrated that he "no longer met or equaled the requirements of any section of the Listing of Impairments at Appendix 1" (*ibid.*). When administrative review failed to revive his benefits, Zebley initiated this combined individual/class action suit in the district court. On his own behalf, Zebley alleged that his benefits had been terminated without substantial evidence. Zebley also claimed, on behalf of the class, that "the Secretary's policy and regulations violated * * * 42 U.S.C. 1382c(a)(3)(A)" because the Secretary refused "to consider all pertinent facts and medical and vocational factors in determining children's eligibility for SSI disability payments" (App., *infra*, 6a). In January, 1984, the district court certified a class consisting of "[a]ll persons who are now, or who in the future will be, entitled to an administrative determination (whether initially, on reconsideration, or on reopening) as to whether supplemental security income benefits are payable on account of a child who is disabled, or as to whether such benefits have been improperly denied, or improperly terminated, or should be resumed" (App., *infra*, 6a).

The district court granted Zebley's motion for partial summary judgment on his individual claim and remanded to the Secretary for calculation and award of benefits (App., *infra*, 6a). The district court also remanded the in-

dividual claims of two named intervenors to the Secretary for further review (*ibid.*). The district court then granted the Secretary's motion for partial summary judgment and dismissed the claims of the plaintiff class challenging the regulations. Relying principally on decisions from the First and Eleventh Circuits rejecting similar challenges to the same regulations, *Hinckley v. Secretary of Health & Human Services*, 742 F.2d 19 (1st Cir. 1984); *Powell v. Schweiker*, 688 F.2d 1357 (11th Cir. 1982), the district court concluded (App., *infra*, 24a) that "the Secretary's listings of impairments . . . [are] not facially invalid or incomplete, seems to provide the necessary flexibility, and, in my view, permits the award of benefits in conformity with the intent of Congress." "If these criteria are being misapplied or misinterpreted," the court noted (*ibid.*), "the remedy lies in the appeal process in individual cases, not in a class-action decree."

3. The Secretary did not appeal from that portion of the judgement disposing of the individual claims of Zebley and the named intervenors. Plaintiff appealed, however, from the judgement upholding the Secretary's regulations, and the court of appeals reversed and remanded the case to the district court, with directions to enter summary judgment in favor of the plaintiff class. The court stated (App., *infra*, 11a) that Congress "expressed unambiguously its intent that 'any' impairment which meets the statutory standard shall be found disabling." The court noted that children are limited to establishing a presumption of disability under the listed impairments, while the adult standard provides for "individualized assessment of the *actual* degree of functional impairment of adults whose medical findings do not entitle them to a *presumption* of disability by meeting or equaling the listings." App., *infra*, 12a (emphasis in original). Because the listed impairments had not been shown to be an exhaustive compilation of medical conditions that could satisfy the

statute, the court held that the standard used for children violates the "clearly expressed" intent of Congress "that children be given the opportunity for individual evaluations comparable to the residual functional capacity assessment for adults" (App., *infra*, 17a).

The court of appeals acknowledged (App., *infra*, 16a) that its decision "places us in the minority among courts which have considered the legality of these regulations." The court, however, found the decisions of these other courts unconvincing. Specifically, the court rejected (App., *infra*, 12a) the Eleventh Circuit's conclusion in *Powell*, 688 F.2d at 1360, that the listing of children's impairments in Part B established criteria sufficiently "comparable to vocational factors for adults" to satisfy Congress's "comparable severity" requirement. The court below concluded (App., *infra*, 13a) that not all impairments of "comparable severity" would be identified by the listings for children and that this shortfall was contrary to Congress's expressed intention that "'any' impairment which meets the statutory standard shall be found disabling." The court also rejected (App., *infra*, 13a) the First Circuit's conclusion in *Hinckley*, 742 F.2d at 23, that the Secretary's regulation "allows for an assessment of a child's mental or physical limitations on an individual basis by providing that a child may be found disabled if his impairment 'is determined by [the Secretary] to be medically equal to an impairment listed in [the Appendix].'" The court below noted (App., *infra*, 13a) that medical equivalence to a listed impairment was based only on medical findings whereas "it is functional impairment which is meant to be evidenced by the medical findings." An individualized determination of functional impairment is therefore "necessary in order to determine whether the degree of a claimant's impairment satisfies the statutory standard for disability" (*ibid.*).

REASONS FOR GRANTING THE PETITION

Congress has not specified how the Secretary is to determine whether a child has a disability of "comparable severity" to one that would entitle an adult to receive disability benefits. The circumstances of adults and children applying for disability benefits are obviously different, since it makes no sense to measure the ability of a two-year-old child to perform substantial gainful employment in the national economy. It is clear that Congress did not intend to mandate such an inquiry, but instead directed the Secretary to determine the best way to correlate children's disabilities with adult disabilities, taking into account the obvious differences between the two categories of claimants. The court of appeals has struck down a reasonable attempt by the Secretary to do just that. In the process, it has placed itself in direct conflict with two other courts of appeals that have upheld the regulations in question. Furthermore, since the district court certified a nationwide class of "all people who are now, or who will be" entitled to children's SSI benefits, the court of appeals has apparently taken upon itself to overrule those two circuits and to preempt other circuits in which the issue is currently pending. The result will be a substantial disruption of the SSI program, requiring rejudication of hundreds of thousands of cases in accordance with a yet unformulated and, it would appear, highly speculative standard.

1. The court of appeals stated (App., *infra*, 11a) that "Congress has expressed unambiguously its intent that 'any' impairment which meets the statutory standard shall be found disabling." That is true; but it begs the question at issue: What is the statutory standard applicable to children? Congress did not say when it first extended the disability program to children in 1972. See Social Security

Amendments of 1972, Pub. L. No. 92-603, § 301, 86 Stat. 1471. The crucial term, "comparable severity," is left undefined in the statute. Congress itself recognized this fact, and subsequently charged the Secretary with the responsibility to "publish criteria to be employed to determine disability (as defined in [42 U.S.C. 1382c(a)(3)(A)] of the Social Security Act) in the case of persons who have not attained the age of 18." Unemployment Compensation Amendments of 1976, Pub. L. No. 94-566, § 501(b), 90 Stat. 2685. The Secretary has done so in a reasonable manner, and his regulations should have been upheld.

a. Congress has provided that an otherwise eligible adult is entitled to disability benefits "if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months" (42 U.S.C. 1382c(a)(3)(A)). Congress did not apply this same test to children for the obvious reason that most children, by simple reason of their age, are already unable to engage in "any substantial gainful activity." For an otherwise eligible child under 18, Congress provided instead that he is eligible for benefits "if he suffers from any medically determinable physical or mental impairment of comparable severity" to an impairment that would entitle an adult to benefits. But Congress nowhere defined "comparable severity." 42 U.S.C. 1382c(a)(3)(A) With respect to an adult, Congress quite clearly mandated an inquiry into whether "his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which

exists in the national economy" (42 U.S.C. 1382c(a)(3)(B)). But Congress recognized, and the House Report accompanying this provision explicitly noted, that such an inquiry could not be applied to children:

[a]n individual (*other than a child under age 18*), would be found disabled if his impairments are so severe that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work * * *.

H.R. Rep. No. 231, 92d Cong., 1st Sess. 148 (1971) (emphasis added).

Congress thus left to the Secretary the task of formulating criteria for measuring children's disabilities pursuant to the Secretary's general authority to "adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits" in disability cases. 42 U.S.C. 405(a), 1383(d)(1). See *Bowen v. Yuckert*, No. 85-1409 (June 8, 1987), slip op. 6-7; *Heckler v. Campbell*, 461 U.S. 458, 466 (1983). Congress made this delegation even more explicit in 1976, in Section 501(b) of the Unemployment Compensation Amendments of 1976, Pub. L. No. 94-566, 90 Stat. 2685. These amendments expressly required the Secretary to "publish criteria to be employed to determine disability (as defined in [42 U.S.C. 1382c(a)(3)(A)] of the Social Security Act) in the case of persons who have not attained the age of 18."³

³ The Senate Finance Committee, which added this provision to the Act, stated that it was designed to "end the present uncertainty which the State agencies and others have with regard to what constitutes

b. Where Congress expressly delegates to an agency the authority to interpret and implement a specific provision of a statute, "[s]uch legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843-844 (1984). "If the agency regulation is not in conflict with the plain language of the statute, a reviewing court must give deference to the agency's interpretation of the statute." *K Mart Corp. v. Cartier, Inc.*, No. 86-495 (May 31, 1988), slip op. 8. See also *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981).

The Secretary—recognizing that children ordinarily do not work and therefore, unlike adults, cannot have their disabling impairments evaluated under an ability-to-work standard—has attempted to meet the "comparable severity" requirement by issuing, in addition to the adult list, a special list of disabling impairments that concentrates on childhood afflictions. This is a reasonable approach that satisfies both the language and intent of the statute. Congress did not direct that the criteria for determining disability of adults and children be identical, only that they be "comparable." As the term is commonly used, "comparable" does not require complete similarity, but only "enough similar characteristics or qualities to make comparison appropriate." See *Dawson v. Myers*, 622 F.2d 1304, 1311 (9th Cir. 1980).

disability for children." S. Rep. No. 1265, 94th Cong., 2d Sess. 25 (1976). Senate Finance Committee Chairman Bentsen explained:

The current situation is that the only definition of disability applied for purposes of SSI eligibility relates to employability * * * a concept obviously irrelevant to children. * * * Section 501 requires [the Secretary] to issue a definition of disability as it relates to children.

122 Cong. Rec. 33,301 (1976).

As the Eleventh Circuit noted in *Powell*, 688 F.2d at 1360, the regulations provide for an identical standard as to three salient points: the "duration" requirement, the listings in Part A, and medical equivalence to the listings. Of the five-part test used for adults (20 C.F.R. 416.920), the Secretary's children's standard omits only the last two: ability to do past work and ability to perform substantial gainful employment in the future. Since these work-related factors cannot sensibly be applied to children, it was entirely reasonable for the Secretary to conclude that the "residual functional capacity" assessment used in applying these factors was inappropriate for children.

The Secretary took into account a child's functional limitations in a different way, by promulgating a separate set of listings in Part B applicable only to children. These listings reflect the Secretary's analysis of the functional limitations of children's impairments, as well as the Secretary's analysis of what impairments are "comparable" to those of adults. In promulgating the regulations, the Secretary stated: "Those impairments which were determined to impact on the child's development to the same extent that the adult criteria have on an adult's ability to engage in substantial gainful activity were deemed to be of 'comparable severity' to the adult listing." 42 Fed. Reg. 14,705 (1977). The Secretary went on to note that "[t]he medical criteria proposed * * * do result in functional limitations or restrictions, depending on the nature of the impairments, and these have been considered." *Id.* at 14,706.

The Secretary provided for an individualized assessment of each child by allowing children to qualify for benefits by showing the medical equivalent of any of the Part B listings. See *Hinckley*, 742 F.2d at 23. Furthermore, some of the Secretary's listings in Part B specifically call for a general assessment of a child's functional capacity. See,

e.g., 101.03C ("[i]nability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene"); 111.06 ("Persistent disorganization or deficit of motor function * * * which * * * interferes with age-appropriate major daily activities * * *"); 112.03 (psychosis resulting in "marked restriction in the performance of daily age-appropriate activities * * * [and] deficiency of age-appropriate self care skills"). Thus, claimants are given an opportunity to establish a functional limitation within the framework of a listed impairment or its medical equivalent.

c. The court of appeals assumed that the Secretary's listing of impairments was incomplete because the regulations governing adults "provid[e] for individualized assessment of the *actual* degree of functional impairment of adults whose medical findings do not entitle them to a *presumption* of disability by meeting or equaling the listings." App., *infra*, 12a (emphasis in original). But just because the adult's listings are not exhaustive, it does not follow that the child's listings are themselves incomplete so as to violate the statutory directive to identify children's disabilities of "comparable severity" to those that would entitle an adult to benefits. As noted, the Secretary has supplied a special listing of a child's disabilities that takes into account the child's functional capacity. A child may establish his eligibility either by showing that he has one of these disabilities or its medical equivalent. This scheme is sufficiently broad and flexible to satisfy the statute, and the court of appeals erred in substituting its own interpretation of the statutory language for that of the Secretary.

The court of appeals would require (App., *infra*, 17a) the Secretary to make "individual evaluations comparable to the residual functional capacity assessment for adults."

Yet the court of appeals offered no suggestion as to how this was to be done. A case-by-case evaluation of whether a child, *if* he were an adult, would be disabled is wholly unworkable. Adults are evaluated on the basis of their age, education and work experience. Yet in making an individualized assessment of whether a child, if he were an adult, could engage in substantial gainful work, how old, how educated, and how experienced should the "hypothetical" adult be? The court of appeals offered no guidance as to how the residual functional capacity assessment for adults translates to the different circumstances of childhood. More fundamentally, the court of appeals offered no justification for substituting its broader standard for the standard promulgated by the Secretary, which itself is plainly a "permissible construction" of the Social Security Act. *Chevron*, 467 U.S. at 843.

The Secretary's interpretation of the statute fully accords with the different purposes behind the disability programs for adults and children. The purpose of disability benefits for adults is to ensure "the basic means of replacing earnings that have been lost as a result of * * * disability" for those who "are not able to support themselves through work * * *." H.R. Rep. No. 231, *supra*, at 146-147. As this Court has noted, "[t]he Social Security Act defines 'disability' in terms of the effect a physical or mental impairment has on a person's ability to function in the workplace." *Heckler v. Campbell*, 461 U.S. 458, 459-460 (1983) (interpreting identical definition of disability in 42 U.S.C. 423). In light of this purpose, it is wholly appropriate for adults to be evaluated upon consideration of their functional capacity to perform work.

By contrast, Congress had a different set of considerations in mind in providing for children's SSI benefits. Recognizing that disabled children from low-income households are "among the most disadvantaged of all Americans," Congress thought that special disability

benefits would be appropriate for such children "because their needs are often greater than those of nondisabled children." H.R. Rep. No. 231, *supra*, at 147-148. Thus, the aim of Congress in establishing children's disability was not to replace lost income, but to provide for the special health care needs of disabled children, such as home health care expenses arising out of a child's medical impairment. It is entirely consistent with this purpose to focus consideration on the severity of the child's medical impairment, without consideration of vocational factors that could be applied only speculatively to a child too young to work in any event.⁴

2. As the court of appeals expressly acknowledged (App., *infra*, 16a), its decision "places [it] in a minority among courts which have considered the legality of these regulations." In *Powell v. Schweiker*, *supra*, a divided panel of the Eleventh Circuit rejected a challenge identical to the one in the case at bar. The court held (688 F.2d 1360) that the standards for children, while different, are not more restrictive than the adult standards and are in fact "comparable" to those for adults in the ordinary meaning of that term. Not only are the standards identical as to three salient points—the listings in Part A, the medical equivalence rule, and the duration requirement—but the standards for children also provide an additional set of listings applicable only to children, some of which take into account the child's functional ability. *Id.* The court accordingly concluded (*id.* at 1361) that the Secretary's regulations constitute a "reasonable interpretation" of the statute that is entitled to deference.

⁴ Despite extensive and comprehensive Congressional oversight of the SSI program and the standards for determining disability, see, e.g., *Schweiker v. Chilicky*, No. 86-1781 (June 24, 1988), slip op. 12-13, Congress has never questioned or altered the child's regulatory standard in the more than ten years since its promulgation.

In *Hinckley*, the First Circuit also held (742 F.2d at 23) that "the Secretary's regulations [regarding children's disability] constitute a reasonable interpretation and application of the statutory definition of 'disability'." The court in that case noted (*id.* at 22) that Congress had clearly recognized that vocational factors used to determine an adult's ability to engage in "substantial gainful employment" are inappropriate for children. The court acknowledged that the statute still requires the Secretary to take into account "not only the nature of the impairment, but also its particular effect on the functional capacity of children" (*id.* at 23). The court concluded (*ibid.*), however, that the Secretary's current regulations satisfy this standard. The regulations not only provide an additional list of impairments designed specifically for children, but also allow for "an assessment of a child's mental or physical limitations on an individual basis" by permitting the child to show the medical equivalent of a listed impairment. *Ibid.* The court also pointed out (*id.* at 23 n.2) that "[s]everal of the impairments in Part B are themselves evaluated in terms of the child's functional capacity." Finally, the Court noted (*id.* at 23) that the plaintiffs were themselves unable to provide an alternative standard for weighing a child's age, education, and functional capacity. Under these circumstances, the court found no basis for "striking down the reasonable standard promulgated by the Secretary * * *." *Ibid.*⁵

⁵ The Fifth and Tenth Circuits have also upheld the regulations at issue here, though against less specific attacks. See *Petroleoni v. Secretary of HHS*, No. 87-2021 (10th Cir. Oct. 26, 1988); *Burnside v. Bowen*, 845 F.2d 587, 590-591 (5th Cir. 1988). The validity of the child's disability regulations is currently under consideration in the Ninth Circuit. *Burt v. Bowen*, No. 88-3990. There are district court cases going both ways on the issue (see App., *infra*, 16a-17a nn.4, 5).

The court of appeals in this case expressly rejected both *Powell* and *Hinckley*, finding neither decision "persuasive" (App., *infra*, 12a). The court below, however, did not simply create a split in the circuits. By virtue of the district court's certification of what appears to be a nationwide class of children's disability claimants,⁶ the court of appeals has apparently overridden the prior contrary decisions of the First and Eleventh Circuits. The court has also preempted the further development of the law in other circuits on this issue. Under these circumstances, review by this Court is plainly warranted.

3. The issue in this case is of considerable practical importance. Because a nationwide class was certified, the court of appeals' ruling would require reevaluation of a substantial number of cases. This suit was filed in 1983. The Department of Health and Human Services estimates that over a quarter of a million cases have applied the existing regulations to deny children's benefits between 1983 and 1988. Even aside from any additional benefits that may have to be paid when a new standard is applied to these cases, HHS estimates that the mere readjudication of these cases would cost over \$41 million.⁷

⁶ The Secretary has asked the district court to clarify the scope of the certified class and to exclude from its scope those jurisdictions in which the issue has already been decided or is currently pending. The district court has not yet ruled on this motion.

⁷ Plaintiffs have also asked the district court, as part of its summary judgment order, to toll the 60-day statute of limitations period contained in 42 U.S.C. 405(g), to include within the class persons who have failed to exhaust their administrative remedies, and to extend the starting date for the class back to July 29, 1975, when the Secretary's regulations relying on the Listing of Impairments to adjudicate children's claims was first published. See 40 Fed. Reg. 31,778, 31,783. Alternatively, plaintiffs have argued that the class should be extended

Finally, the development of an entirely new standard "comparable" to the vocational factors used for adults would itself entail a substantial administrative endeavor. The court of appeals' ruling (App., *infra*, 20a) that the Secretary must give children "an opportunity for individualized assessment of [the severity] of their functional limitations" does not explain how this is to be done. Thus, the Secretary presumably would need to convene a panel of experts from the health care profession to aid in formulating a new standard and develop procedures and training programs to implement the new standard. If such a standard requires the use of child guidance experts similar to the vocational experts used in adult cases, implementation could be even more costly and time consuming.

back to March 16, 1977, the date the Part B children's listings were published. See 42 Fed. Reg. 14,705. The Secretary has opposed these requests, but the district court has yet to rule on them. Obviously, if the district court extends the size of the class in any of these ways, the practical consequences of the court of appeals' ruling would be proportionally increased.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted.

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FEBRUARY 1989

APPENDIX A

**UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

No. 87-1692
(D.C. Civil No. 83-3314)

ZEBLEY, BRIAN, BY HIS PARENT AND NATURAL GUARDIAN,
ZEBLEY, JOHN, ON BEHALF OF HIMSELF AND ON BEHALF OF A
CLASS OF ALL OTHERS SIMILARLY SITUATED

INTERVENOR: RAUSHI, EVELYN, BY HER PARENT AND
NATURAL GUARDIAN, RAUSHI, MARY

INTERVENOR: LOVE, JOSEPH, JR., BY HIS PARENT AND
NATURAL GUARDIAN, MARGARITE LOVE, APPELLANTS

VS.

OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND
HUMAN SERVICES

Appeal from the United States District Court for
the Eastern District of Pennsylvania

(Filed Aug. 10, 1988)

OPINION OF THE COURT

Before: GIBBONS, Chief Judge, and MANSMANN and
COWEN, Circuit Judges.

MANSMANN, *Circuit Judge*:

This appeal requires us to examine the policies and procedures used by the Secretary of Health and Human Services in determining whether a child is "disabled," so as to be eligible for Supplemental Security benefits. A child is

defined by statute to be disabled by "*any* medically determinable physical or mental impairment of *comparable severity*" to one which would enable an adult to qualify for disability benefits. 42 U.S.C. § 1382c(a)(3)(A) (emphasis added). The Secretary's regulatory scheme confines eligibility for benefits to children who can demonstrate an impairment with medical findings that meet or equal those of one of the specific impairments listed in an Appendix to the regulations. 20 C.F.R. § 416.924.

The Appendix has not been shown to provide an exhaustive catalog of medical findings which could, singly or in combination, describe, "any" impairment which might satisfy the statutory standard of "comparable severity." Therefore, we hold that the Secretary's regulatory scheme is too restrictive to be consistent with the statute. The statutory standard requires that children, like adults, be given an opportunity for individualized assessment of the severity of their functional limitations.

Accordingly, we will vacate the order of the district court with respect to the claim of the plaintiff class that the procedure set forth in 20 C.F.R. § 416.924 is inconsistent with the statutory mandate of 42 U.S.C. § 1382c(a)(3)(A), and we will remand the case for the entry of summary judgment for the class with respect to that claim. We will, however, affirm the order of the district court with respect to the additional claim of the plaintiff class that the regulations are inconsistent with the Social Security Disability Benefits Reform Act of 1984, 42 U.S.C. § 1381 *et seq.*

I.

In 1974, to complement the existing contributory social insurance program, Congress established the Supplemental Security Income program to assist "individuals

who have attained age 65 or are blind or disabled." 42 U.S.C. § 1381. Although welfare benefits are available under a separate program for needy families with children, Congress included disabled children under the somewhat more generous Supplemental Security Income program in the "belief that disabled children who live in low-income households are certainly among the most disadvantaged of all Americans and that they are deserving of special assistance in order to help them become self-supporting members of our society." H.R. Rep. No. 231, 92nd Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Admin. News 4989, 5133.

The precise statute provides that:

An individual shall be considered to be disabled for purposes of this subchapter if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (*or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity*).

42 U.S.C. § 1382c(a)(3)(A) (emphasis added).

The Secretary has promulgated regulations setting forth the procedure to be followed in determining whether a claimant meets the statutory definition of disability. Under the regulations, an adult or a child who is not performing any substantial gainful activity, and who has an impairment which meets the duration requirement and has medical findings which meet or equal the findings associated with a listing of specific impairments set forth in Appendix 1 to the regulations, will be found disabled under the regulations without considering any evidence

except the medical findings. 28 C.F.R. § 416.920(d); § 416.924(b). Medical equivalence to a listed impairment must be based on medical findings. 20 C.F.R. § 416.926(b). The functional consequences of combined impairments, "irrespective of their nature, *cannot* justify a determination of equivalence with a listed impairment." Soc. Sec. Rul. 83-19 (emphasis in original).

Part A of the Appendix sets forth medical criteria for evaluating impairments in adults and, where appropriate, in children as well. 20 C.F.R. Chapter III, Part 404, Subpart P, Appendix I. Part B of the Appendix lists additional medical criteria applicable to children only. *Id.* Part B is to be used first in evaluating disability for a person under age 18. 20 C.F.R. § 416.925(b)(2).

If an adult's medical findings do not meet or equal the listings, the regulations provide for an individualized assessment of the *actual* degree of functional impairment. 20 C.F.R. § 416.920(e) & (f).¹

No such individual assessment is provided for children in the Secretary's regulations. If a child's medical findings

¹ 20 C.F.R. § 416.920(e) & (f) provide:

(e) Your impairment(s) must prevent you from doing past relevant work. If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment(s), we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled.

(f) Your impairment(s) must prevent you from doing other work. (1) If you cannot do any work you have done in the past because you have a severe impairment(s), we will consider your residual functional capacity and your age, education, and past work experience to see if you can do other work. If you cannot, we will find you disabled. (2) If you have only a marginal education, and long work experience (i.e., 35 years or more) where you only did arduous unskilled physical labor, and you can no longer do this kind of work, we use a different rule (see § 416.962).

do not meet or equal the listings, the child may not be found to be disabled regardless of the severity of the actual impairment.²

II.

Brian Zebley was born July 13, 1978 and received Supplemental Security Income (SSI) disability benefits as a disabled child from September 12, 1980 until January 26, 1983. An Administrative Law Judge (ALJ) for the Social Security Administration, Department of Health and Human Services, determined later that the medical evidence of congenital brain damage with spastic right hemiparesis, mental retardation, development delay, eye problems and musculoskeletal impairments on the right side no longer met or equaled the requirements of any section of the Listing of Impairments at Appendix I. Therefore, the Administration found that Brian's childhood disability ceased as of June, 1982 and that his eligibility for SSI terminated August 31, 1982. The Appeals Council denied review and, on July 1, 1983, Zebley filed a class action complaint against the Secretary in the district court.

Zebley asserted as an individual that the decision to terminate his benefits was not supported by substantial

² 20 C.F.R. § 416.924 (1980) provides:

How we determine disability for a child under age 18.

We will find that a child under age 18 is disabled if he or she—

- (a) Is not doing any substantial gainful activity; and
- (b) Has a medically determinable physical or mental impairment(s) which compares in severity to any impairment(s) which would make an adult (a person age 18 or over) disabled. This requirement will be met when the impairment(s)

(1) Meets the duration requirement; and

(2) Is listed in Appendix I of Subpart P of Part 404 of this chapter; or

(3) Is determined by us to be medically equal to an impairment listed in Appendix I of Subpart P of Part 404 of this chapter.

evidence. On behalf of the class, he asserted that the Secretary's policy and regulations violated the Social Security Act, specifically 42 U.S.C. § 1382(a)(3)(A), by the Secretary refusing to consider all pertinent facts and medical and vocational factors in determining children's eligibility for SSI disability payments.

Joseph Love, Jr., whose claim for SSI benefits was denied, and Evelyn Raushi, whose benefits were terminated, filed petitions to intervene on September 2, 1983 and November 1, 1983 respectively. On January 10, 1984, the district judge certified a class of

"[a]ll persons who are now, or who in the future will be, entitled to an administrative determination (whether initially, on reconsideration, or on reopening) as to whether supplemental security income benefits are payable on account of a child who is disabled, or as to whether such benefits have been improperly denied, or improperly terminated, or should be resumed."

On October 12, 1984, the district court granted Zebley's motion for partial summary judgment. The court reversed the Secretary's decision on Zebley's individual claim and remanded it to the Secretary for calculation and award of benefits.

On March 13, 1985, upon the Secretary's uncontested motion, the district court remanded Evelyn Raushi's claim to the Secretary for review in accordance with the Social Security Benefits Reform Act of 1984, 42 U.S.C. § 1381 *et seq.* (Supp. 1987).

On July 16, 1986, the district court granted the Secretary's motion for partial summary judgment and dismissed the claims of the plaintiff class challenging the Secretary's regulations.

On April 23, 1987, pursuant to the parties' stipulation, the claim of intervenor Joseph Love was remanded to the

Secretary for review under the Social Security Benefits Reform Act of 1984.

On October 26, 1987, the district court certified the entry of final judgment in accordance with Fed. R. Civ. P. 54(b). On November 5, 1987, plaintiffs, intervenors and all members of the certified class appealed. Numerous amici curiae filed briefs in support of the appellants.³

III.

The plaintiffs challenge only the dismissal of the certified class' claim that the Secretary's regulatory scheme for determining disability in children is inadequate to identify "*any* medically determinable physical or mental impairment of *comparable severity*" to one which would disable an adult as required by 42 U.S.C. § 1382(a)(3)(A) (emphasis added). The plaintiffs argue that the regulatory scheme violates the statutory standard by restricting eligibility for benefits to children who can demonstrate an impairment with medical findings that meet or equal those

³ Briefs in support of the plaintiff class were filed by the following amici curiae:

American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, Association for Retarded Citizens of the United States, Center for Law and Social Policy, National Alliance for the Mentally Ill, National Association of Private Residential Resources, National Association of Protection and Advocacy Systems, National Mental Health Association, Pennsylvania Protection and Advocacy, Inc., Pennsylvania Tourette Syndrome Association, Sickle Cell Genetic Disease Council, Spina Bifida Coalition of Pennsylvania, Pennsylvania Association for Retarded Citizens, United Cerebral Palsy of Pennsylvania, Eastern Pennsylvania Chapter of the Arthritis Foundation, Parent Education Network, Chester County Right to Education Task Force, Media Child Guidance Community Mental Health/Mental Retardation Services, Inc., Mental Health Association in Indiana County, Inc., Spina Bifida Association of the Delaware Valley, Inc., The Spina Bifida Association of Greater Los Angeles, Welfare Recipients League, and Russell Champaign.

of one of the specific impairments listed in Appendix 1 to the regulations. The plaintiffs assert that the statutory standard requires the same individualized assessment of the severity of a child's functional limitations as is available for adults who are not able to establish their disability on the basis of medical evidence alone.

Between the filing of the complaint and the entry of the final order in this case, Congress passed the Social Security Disability Benefits Reform Act of 1984, 42 U.S.C. § 1381 *et seq.* The plaintiffs assert that the regulatory scheme violates the Reform Act, which requires the Secretary to consider the medical severity of a combination of impairments without regard to whether any individual impairment, if considered separately, would be of sufficient medical severity to be the basis of eligibility for benefits. 42 U.S.C. § 1382(a)(3)(G) and (H) (Supp. 1987).

The plaintiffs also argue that the Secretary has ignored section 5(a) of the Reform Act which, plaintiffs assert, directs the Secretary to revise the "Mental and Emotional Disorders" listings for children.

The district court had subject matter jurisdiction pursuant to 42 U.S.C. § 405(g) and 42 U.S.C. § 1383(C)(3). We have appellate jurisdiction pursuant to 28 U.S.C. § 1291.

IV.

The question on our review of district court decisions in suits challenging Social Security regulations is whether the district court applied the correct legal precepts in reaching its conclusions. *Barnes v. Cohen*, 749 F.2d 1009, 1013 (3d Cir. 1984), *cert. denied*, 471 U.S. 1061 (1985). Our review of the district court's interpretation and application of legal precepts is plenary. *Gaines v. Amalgamated Ins. Fund*, 753 F.2d 288, 290 (3d Cir. 1985).

A reviewing court must defer to an agency's interpretation of a statute which the agency administers so long as the interpretation is reasonable. *Lugo v. Schweiker*, 776 F.2d 1143, 1147 (3d Cir. 1985). Section 1383(d)(1) of the SSI statute grants the Secretary "full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions. . . ." Because Congress did not describe explicitly a *method* for determining whether a claimant is disabled, our review is limited to determining if the regulation in question, 20 C.F.R. § 416.924, exceeds the Secretary's authority or is arbitrary or capricious. *Bowen v. Yuckert*, ___ U.S. ___, 107 S.Ct. 2287 (1987); *Heckler v. Campbell*, 461 U.S. 458, 466 (1983).

The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent. *Lugo v. Schweiker*, 776 F.2d at 1147. The agency's regulations must give effect to the unambiguously expressed intent of Congress. *Id.*

A.

The plaintiffs and amici curiae argue that the Secretary's child disability evaluation policy is inconsistent with the statute because it fails to afford an individualized assessment of the actual extent of functional impairment resulting from a child's medical pathology. They assert that the regulatory procedure fails to identify many children who are disabled as defined by the statute and the regulations. The following assertions by the Spina Bifida Association of Greater Los Angeles are illustrative of the numerous examples alleged by amici to demonstrate the

inadequacy of the Secretary's exclusive reliance on the medical listings.

Many of the disability problems children with spina bifida have, and which result in functional limitations, are not catalogued in the children's listings of impairments: gastrostomy tubes into the stomach through which a child is fed; tracheostomies which are openings into the neck through which the child breathes and through which the child is suctioned to prevent aspiration or pneumonia; and shunts to remove excess fluid from the head to prevent or minimize brain damage from the pressure of water on the brain. As a result of having functional limitations due to disability problems not catalogued in the Listings, some severely disabled spina bifida children have not been able to qualify for Supplemental Security Income (SSI).

Brief of Amici Curiae at p. 2.

In interpreting a statute, our starting point is the language itself; it is to be presumed that the legislative purpose is expressed by the ordinary meaning of the words used, and if the statutory language is clear, it is not necessary to examine legislative history. *Barnes v. Cohen*, 749 F.2d 1009, 1013 (3d Cir. 1984), *cert. denied*, 471 U.S. 1061 (1985).

The statute provides that:

An individual shall be considered to be disabled for purposes of this subchapter if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (*or, in the case of a child under the age of 18, if he suffers*

from any medically determinable physical or mental impairment of comparable severity).

42 U.S.C. § 1382c(a)(3)(A) (emphasis added).

In keeping with the statute, the regulations provide that a child will be found disabled if "suffering from any medically determinable physical or mental impairment which compares in severity to an impairment that would make an adult (a person over age 18) disabled." 20 C.F.R. § 416.906. The Secretary adopted listings for children which were determined to be of "comparable severity" to the adult criteria. *Id.* According to the regulations, the listed impairments "are considered severe enough to prevent a person from doing any gainful activity." 20 C.F.R. § 416.925. Thus, the functional consequence of the listed impairments is presumed.

When a court reviews an agency's construction of a statute which it administers, the court is confronted with two questions: whether Congress has directly spoken on the precise question at issue; if the statute is silent or ambiguous with respect to the specific issue the question for the court is whether the agency's answer is based on a permissible construction of the statute. *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), *reh'g denied*, 468 U.S. 1227; *Kean v. Heckler*, 799 F.2d 895 (3d Cir. 1986).

Congress has expressed unambiguously its intent that "any" impairment which meets the statutory standard shall be found disabling. Therefore, the Secretary's regulatory method for determining disability must be adequate to identify *any* qualifying impairment.

The listings, however, do not purport to be an exhaustive compilation of medical conditions which could impair functioning to the extent necessary to satisfy the statutory standard for liability. The regulations recognize

this by providing for individualized assessment of the *actual* degree of functional impairment of adults whose medical findings do not entitle them to a *presumption* of disability by meeting or equaling the listings. 20 C.F.R. § 416.920(e) and (f).

As we explained above, the regulations do not provide for such individual assessment for children, although they are entitled by statute to receive benefits if suffering from "any" impairment of "comparable severity" to one which would render an adult unable to engage in "substantial" gainful activity. It is the expressed intention of Congress that children be given the opportunity to show that they suffer from "any" impairment of "comparable severity" to one which would actually, even if not presumptively, disable an adult.

Therefore we find that the regulations are inconsistent with the statute in precluding a finding that a child is disabled unless his impairment meets or equals a listed one.

The district court rejected the challenge to the validity of the regulations relying principally on the precedential force of two appellate court decisions, *Powell v. Schweiker*, 688 F.2d 1357 (11th Cir. 1982), *reh'g denied*, 694 F.2d 727 and *Hinckley v. Secretary of HHS*, 742 F.2d 19 (1st Cir. 1984). The Secretary's arguments on this appeal are essentially those adopted by the courts in *Powell* and *Hinckley*. We find neither decision persuasive.

The Court of Appeals for the Eleventh Circuit in *Powell* considered the argument that the Secretary's regulations were inadequate in failing to provide criteria for children, comparable to vocational factors for adults, against which to compare the medical evidence in determining the actual degree of a child's functional impairment. The court, however, concluded that the regulations were "reasonably

related to the purposes of the legislation" because some impairments of "comparable severity" would be identified by certain of the listings in Part B which evaluate the degree of medical impairment in terms of a child's ability to perform age-appropriate activities. 688 F.2d at 1360. We decline to accept this reasoning.

We reiterate that Congress has unambiguously expressed its intent that "any" impairment which meets the statutory standard shall be found disabling. The Secretary's regulatory method for determining disability, which is adequate to identify only *some* comparable impairments is not enough.

Similarly, the Court of Appeals for the First Circuit concluded in *Hinckley* that the regulation "allows for an assessment of a child's mental or physical limitations on an individual basis by providing that a child may be found disabled if his impairment 'is determined by [the Secretary] to be medically equal to an impairment listed in [the Appendix].'" 742 F.2d at 23. We also decline to accept this conclusion.

Medical equivalence to a listed impairment must be based on medical findings. 20 C.F.R. § 416.926(b). In the final analysis, it is functional impairment which is meant to be evidenced by the medical findings. It is *only* impaired ability to function which results in disability. Nevertheless, the Secretary has made it clear that the functional consequences of combined impairments, "irrespective of their nature, *cannot* justify a determination of equivalence with a listed impairment." Soc. Sec. Rul. 83-19 (emphasis in original). Therefore, something more is necessary in order to determine whether the degree of a claimant's impairment satisfies the statutory standard for disability.

The Secretary argues vigorously that the Staff of the Senate Committee on Finance reporting publication of the

regulations, approves the regulations as consistent with the statute, an argument which was adopted by the *Hinckley* court. 742 F.2d at 22. The report noted that "[t]he non-medical vocational factors were not applied to the children for basically the same reasons they had not been applied to disabled widows in earlier legislation, i.e., that as a group they had not had enough attachment to the labor force to make application of these factors feasible." Staff of Senate Comm. on Finance, 95th Cong., 1st Sess., The Supplemental Security Income Program 125 (Comm. Print 1977). We disagree that children's and widows' similar lack of attachment to the labor force justifies the Secretary's limited procedures with respect to children.

At the time Congress amended the Social Security Act to provide for widows' benefits, the existing test for disability was the one which was later adopted for SSI benefits, i.e., the ability to engage in "substantial gainful activity." In providing for widows' benefits, Congress explicitly authorized a more stringent disability standard. The statute provides as follows:

A widow, surviving divorced wife, or widower shall not be determined to be under a disability . . . unless his or her physical or mental impairment or impairments are of a level of severity which *under regulations prescribed by the Secretary* is deemed to be sufficient to preclude an individual from engaging in *any* gainful activity.

The legislative history shows that Congress was well aware of the difference. The House version of the bill offered inability to engage in "any" gainful activity as the standard. H.R. Conf. Rep. No. 1030, 90th Cong., 1st Sess., reprinted in 1967 U.S. Code Cong. & Admin. News 2834, 3197. The Senate version was more liberal, using the

"substantial" gainful activity standard. *Id.* The conference agreement settled on the language from the House bill. *Id.*

In enacting the SSI plan, Congress explicitly provided that adult eligibility is to be measured by inability to engage in "substantial" gainful activity, and that children's disability is to be evidenced by "any" impairment of "comparable severity." 42 U.S.C. § 423(d)(2)(B) (emphasis added). Significantly, the statute did *not* provide that children's impairments need be comparable to those which would disable an adult from *any* gainful activity.

The finance committee report cited by the Secretary postdated the passage of the statute by approximately five years, and post-enactment comment by a legislative committee generally does not serve as a reliable indicator of congressional intent. *Oscar Mayer & Co. v. Evans*, 441 U.S. 750 (1979). Even if the report can be said to evidence Congress' implicit approval of ignoring vocational factors in gauging disability in children, this does not mean that the Secretary is not required to assess a child's functional impairment against appropriate criteria *comparable* to vocational factors for adults.

The court in *Hinckley* expressed its concern that in requiring the Secretary to measure the actual degree of functional impairment caused by each child's medical condition(s), the court would also have to devise a standard against which to assess when a child's remaining capabilities are comparable to an adult's inability to engage in "substantial gainful activity." 742 F.2d at 23. We see no necessity for such an intrusion upon the Secretary's authority.

The Secretary has already interpreted the statutory standard of "comparable severity" to comprehend those impairments which impact on a child's "development" to the same extent that a disabling impairment impacts on an

adult's ability to engage in substantial gainful activity. 42 Fed. Reg. 14705 (1977).

We recognize that our decision places us in the minority among courts which have considered the legality of these regulations.⁴ Nevertheless, our review of authorities upholding the regulations⁵ does not persuade us to abandon our conclusion that the Secretary's prescribed method for determining disability in children is too restrictive to be consistent with the statute.

⁴ The following cases support the position of the plaintiff class: *See Mental Health Assoc. of Minnesota v. Schweiker*, 554 F. Supp. 157 (D. Minn. 1982), *aff'd* 720 F.2d 965 (8th Cir. 1983) (Sec'y may not presume that mentally impaired claimants are not disabled unless they meet the listings); *Burt v. Bowen*, No. C-85-1033-JBH, (E.D. Wash. May 12, 1988) (Secretary does not possess statutory authority to limit children's disability to less than any impairment of comparable severity to one which would support an award to an adult after step 3 in the sequential process); *Gordon v. Secretary of HEW*, No. CV 75-4088-F(G) (C.D. Calif. May 6, 1977) (remand because of exclusive application of listed impairment test—Secretary failed to consider whether child might be disabled under language in regulations to effect that medical equivalence determination must give "appropriate consideration of the particular effect of disease processes in childhood" 20 C.F.R. § 416.904, which is intended to extend to children the same individualized determination of disability as is available to adults). *See also, Bowen v. City of New York*, 476 U.S. 467 (1986) (SSA rules for determining disability based on mental impairment are illegal in confining mental disability determinations to the narrow "listings").

⁵ The following authorities arguably support the Secretary's position: *Burnside v. Bowen*, 845 F.2d 587 (5th Cir. 1988) (minor claimant with cystic fibrosis was evaluated under proper legal standards); *Hinckley v. Secretary of H.H.S.*, 742 F.2d 19 (1st Cir. 1984) (Secretary's guidelines for determining whether a child under 18 is disabled are valid); *Powell v. Schweiker*, 688 F.2d 1357, (11th Cir. 1982), *reh'g denied*, 694 F.2d 727 (failure to carry over adult evaluation scheme for children's disabilities was not inconsistent with the statutory definition of disability); *Wills v. Secretary*, No. M87-72 CA, 1987 WL 46333

A reviewing court must reject administrative constructions of a statute, whether reached by adjudication or by rule making, that are inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement. *Securities Industry Ass'n v. Board of Governors of Federal Reserve System*, 468 U.S. 137 (1984). We are persuaded that in the statutory directive that "any" impairment may be disabling if severe enough, Congress has clearly expressed an intention that children be given the opportunity for individual evaluations comparable to the residual functional capacity assessment for adults. This intent is contrary to that of the agency, which is to restrict children to listed impairments.

Therefore we will vacate the district court's order of summary judgment for the Secretary and remand with the direction to enter summary judgment in favor of the plaintiff class as to this claim.

B.

The plaintiffs' second argument is that the regulations are inconsistent with the 1984 Reform Act with respect to children because the regulations do not require consideration of the "combined effect of all impairments" and "all evidence available."

(W.D. Mich., Dec. 14, 1987). (The Secretary has permissibly construed the "comparable severity" language of the statute); *Blankenship v. Schweiker*, No. 79-3134 (S.D. W.Va. June 19, 1981) ("comparable severity" doesn't mean that vocational factors test must be applied in determining children's disability because statute specifically excludes children from discussion of work activity standard); *Zukow v. Harris*, No. 80-3199 (M.D. Tenn. December 15, 1980). (Secretary need not consider whether child of [sic] disability claimant's impairments prevent her from engaging in substantial gainful activity because statute and legislative history exclude children when discussing work activity, and typical child has not [sic] expectation of income but for the existence of an impairment).

This claim need not detain us long because its resolution follows from our disposition of the previous issue. The 1984 Disability Reform Act does require that the Secretary shall consider the combined impact of multiple impairments throughout the disability determination process, 42 U.S.C. § 1382c(a)(3)(G) (Supp. 1987), and that the Secretary shall consider all evidence available, 42 U.S.C. § 1382c(a)(3)(H) (Supp. 1987).

The regulations recognize those mandates by providing expressly that multiple impairments will be considered in assessing medical equivalence, 20 C.F.R. § 416.926, and by providing generally that the combined effect of all of a claimant's impairments will be considered throughout the disability determination process, 20 C.F.R. § 416.923. As we held earlier, an individualized determination of the degree of functional incapacitation is required by statute during the disability determination process for children. Existing regulations will serve to assure consideration of multiple impairments during that additional evaluative step.

C.

The Plaintiffs' final contention is that the Secretary has violated Section 5(a) of the 1984 Reform Act by failing to revise the mental disorder listings for children. The Secretary contends that the Reform Act directed the Secretary to revise only the listings of mental impairments for adults and not those for children. The mandate of the Reform Act reads as follows:

The Secretary of Health and Human Services (hereafter in this Section referred to as the "Secretary") shall revise the criteria embodied under the category "*Mental Disorders*" in the "Listing of Impairments" in effect on the date of the enactment of this Act [Oct. 9,

1984] under the Appendix 1 of Subpart P of Part 404 of Title 20 of Code of Federal Regulations. The revised criteria and listings, alone and in combination with assessments of the residual functional capacity of the individuals involved, shall be *designed to realistically evaluate the ability of a mentally impaired individual to engage in substantial gainful activity in a competitive workplace environment*. Regulations establishing such revised criteria and listings shall be published no later than 120 days after the date of the enactment of this act [Oct. 9, 1984].

42 U.S.C. § 421 note (Supp. 1987) (emphasis added).

In August, 1985, the Secretary issued new listings under the category "Mental Disorders" in Appendix 1, Part A, which are applicable to adults and children. The Secretary did not revise the listings under the category "Mental and Emotional Disorders" in Appendix 1, Part B, which are applicable to children only. Since the statutory time limit for revising the listings has expired, the plaintiffs request the equitable remedy of a court-ordered timetable for revision of the children's listings.

The Secretary argues that Congress mandated revision only of the category expressly designated by the statute. The precise designation "Mental Disorders" appears only in Part A of Appendix 1 of the regulations. The comparable category in Part B is entitled "Mental and Emotional Disorders." Therefore, argues the Secretary, Congress intended only that the Part A listings be revised.

In addition, the Secretary points to Congress' expressed purpose that the revision result in criteria and listings "designed to realistically evaluate the ability of a mentally impaired individual to engage in a competitive workplace environment." The argument proceeds that since children, for the most part, have no connection with the workplace,

Congress' manifest purpose is to achieve revision of only the adult criteria.

An agency's interpretation of a statute which it administers is entitled to deference, and need not be the only reasonable one in order to gain judicial approval. *Lugo v. Schweiker*, 776 F.2d 1143, 1147 (3d Cir. 1985). Plaintiffs and amici urge that the children's listings are based on outmoded medical and scientific concepts of disability assessment. They are unable, however, to point to any unambiguous evidence of congressional intent which would compel us to find the Secretary's interpretation of the Reform Act to be "arbitrary and capricious." *Id.* Neither the legislative history nor the statutory language itself makes any reference to whether Congress intended that the children's listings in Part B be included in the mandated revision. If a statute is silent or ambiguous with respect to the specific issue, and the agency's construction is reasonable, a court must defer to that construction, although it may not be the only or even the most reasonable one. *Kean v. Heckler*, 799 F.2d 895 (3d Cir. 1986). Accordingly, we will defer to the Secretary's interpretation of the statute.

VI.

In accordance with the foregoing, we will vacate in part the order of summary judgment in favor of the Secretary and remand to the district court with the direction that summary judgment be entered in favor of the plaintiff class as to the claim that the Secretary is required by statute to give child claimants for SSI benefits an opportunity for individualized assessment of their functional limitations.

APPENDIX B

UNITED STATES DISTRICT COURT E.D. PENNSYLVANIA

Civ. A. No. 83-3314

JOHN ZEBLEY, ET AL.

v.

MARGARET M. HECKLER (BOWEN), SECRETARY OF
HEALTH AND HUMAN SERVICES

July 16, 1986

MEMORANDUM AND ORDER

FULLAM, Chief Judge.

Persons in certain economic categories are entitled to supplemental security income ("SSI") under the Social Security Act if they are disabled. The statute defines disability as follows:

"An individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of

comparable severity). . . ." 42 U.S.C. § 1382c(a)(3) (A). (Emphasis added.)

Plaintiffs in this class action challenge the regulation which has been adopted by the Secretary for determining whether a child is disabled within this definition, 20 C.F.R. § 416.923, which provides:

"How we determine disability for a child under age 18.

We will find that a child under age 18 is disabled if he or she—

(a) is not doing any substantial gainful activity; and

(b) Has a medically determinable physical or mental impairment(s) which compares in severity to any impairment(s) which would make an adult (a person age 18 or over) disabled. This requirement will be met when the impairment(s)—

(1) Meets the duration requirement; and

(2) Is listed in Appendix 1 of Subpart P of Part 404 of this chapter; or

(3) Is determined by us to be medically equal to an impairment listed in Appendix 1 of Subpart P of Part 404 of this chapter.

It is common ground that, in evaluating an adult's disability, a five-step sequential analysis is used: (1) Is the claimant gainfully employed? (2) Is the claimed impairment sufficiently severe to significantly limit the claimant's physical or mental ability to do basic work? (3) Does the impairment meet the duration requirement, and is it listed in Appendix 1 or equal to a listed impairment? [if so, the analysis stops at this point, and benefits are awarded] (4) Does the claimant have sufficient residual functional capacity to perform his previous work? And (5) if not, does the claimant have residual functional capacity, con-

sidering his age, education and work experience, to engage in gainful employment? In the case of a child, however, only the first three steps in the analysis are followed (and the first step is virtually automatic).

The net result, according to plaintiffs, is that an adult claimant whose impairment is not of the prescribed severity or is not listed can nevertheless establish eligibility for benefits by showing that he lacks residual functional capacity for gainful employment. The contention is that Congress specified that children are eligible for SSI benefits if they suffer from a physical or mental impairment comparable to that which would prevent an adult from engaging in gainful employment, hence a child claimant should have the same opportunity to prove inability to function adequately in a child's environment as that which is provided the adult claimant under the "residual functional capacity" rubric.

Strikingly similar challenges to the regulation have been rejected by the only two appellate courts to consider the issue, *Powell v. Schweiker*, 688 F.2d 1357 (11th Cir. 1982) and *Hinkley v. Secretary of HHS*, 742 F.2d 19 (1st Cir. 1984). In both cases, it was held that the Secretary's regulations and directives for determining the disability of children are not inconsistent with the statute—although, admittedly, other approaches, including a child's equivalent of "residual functional capacity" would have been as good or better.

Attempting to escape the precedential force of the cited cases, plaintiffs argue that their challenge is not so much to the elimination of the fourth and fifth steps of the sequential analysis (*i.e.*, depriving the child-claimant of "vocational factors"/"residual functional capacity"), as to the differences between children and adults in the way in which the third step of the sequential analysis is applied. Acknowledging that children's mental and physical im-

pairments are different from those of adults, and have differing impacts—hence, that providing a listing applicable to both children and adults, and a separate, additional listing for children, is not inappropriate—plaintiffs nevertheless contend that, in many situations, the wooden and inflexible application of the prescribed standards for evaluating medical conditions, particularly combinations of conditions, results in a finding of “not disabled” in the case of a child, when an adult with less severe impairments would be found disabled.

Plaintiffs’ argument may well be valid, in many cases; but errors in applying the regulations in some cases do not demonstrate invalidity of the regulations themselves. Part B of the Secretary’s listings of impairments, 20 C.F.R. § 416.925, is not facially invalid or incomplete, seems to provide the necessary flexibility, and, in my view, permits the award of benefits in conformity with the intent of Congress. If these criteria are being misapplied or misinterpreted, the remedy lies in the appeal process in individual cases, not in a class-action decree.

I have concluded, therefore, that the claims of plaintiff class challenging the Secretary’s regulations must be dismissed. The defendant’s Motion for Summary Judgment will, to that extent, be granted, without prejudice to the claims of the named plaintiffs, intervenors and individual class members.

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 87-1692

BRIAN ZEBLEY, ET AL.

VS.

OTIS BOWEN, M.D., ETC.,

[Filed Oct. 18, 1988]

SUR PETITION FOR REHEARING

Present: GIBBONS, Chief Judge, SEITZ, HIGGINBOTHAM, SLOVITER, BECKER, STAPLETON, MANSMANN, GREENBERG, HUTCHINSON, SCIRICA, and COWEN, Circuit Judges.

The petition for rehearing filed by appellants in the above entitled case having been submitted to the judges who participated in the decision of this court and to all other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is denied. Judges Seitz and Hutchinson would have granted rehearing in banc.

BY THE COURT,

/s/ CAROL LOS MANSMANN
Circuit Judge

FILED

APR 20 1989

**JOSEPH F. SPANIOLO, JR.
CLERK**

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1988

NO. 88-1377 (2)

LOUIS SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES,

Petitioner,

v.

BRIAN ZEBLEY, JOSEPH LOVE, JR., et al.,

Respondents.

**RESPONDENTS' BRIEF IN OPPOSITION TO
PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

Brian Zebley, Joseph Love, Jr. and Evelyn Raushi, on behalf of themselves and members of their class, respond in opposition to the petition for writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

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RECASTING OF QUESTION PRESENTED

Are children seeking Supplemental Security Income disability benefits entitled to an individualized determination of all their impairments and functional limitations based upon the requirement of 42 U.S.C. § 1382c(a)(3)(A) that they be found disabled if their mental or physical impairments are of "comparable severity" to that which would cause an adult to be found disabled?

OPINIONS BELOW

The opinion of the court of appeals is reported at 855 F.2d 67 (cert. pet. 1a-20a). The memorandum and order of the district court are reported at 642 F. Supp. 220 (cert. pet. 21a-24a).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1382c(a)(3)(A) provides in pertinent part:

An individual shall be considered to be disabled * * * if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

42 U.S.C. § 1382c(a)(3)(G) (Supp. 1988) provides:

In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Secretary shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Secretary does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

42 U.S.C. §§ 1382c(a)(3)(H) (Supp. 1988), 423(d)(5)(B) (Supp. 1988) provides:

In making any determination with respect to whether an individual is under a disability or continues to be under a disability, the Secretary shall consider all evidence available in such individual's case record . . .

20 C.F.R. § 416.924 provides:

We will find that a child under age 18 is disabled if he or she -

(a) Is not doing any substantial gainful activity; and

(b) Has a medically determinable physical or mental impairment(s) which compares in severity to any impairment(s) which would make an adult (a person age 18 or over) disabled. This requirement will be met when the impairment(s) -

(1) Meets the duration requirement; and

(2) Is listed in Appendix 1 of Subpart P of Part 404 of this chapter; or

(3) Is determined by us to be medically equal to an impairment listed in Appendix 1 of Subpart P of this chapter.

20 C.F.R. § 416.920a(c)(3) provides:

If you have a severe [mental] impairment(s) but the impairment(s) neither meets or equals the listings, we must then do a residual functional capacity assessment, unless you are claiming benefits as a disabled child.

20 C.F.R. § 416.925(a) provides:

Purpose of the Listing of Impairments. The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity.

STATEMENT OF THE CASE

Statutory Framework

1. To complement the Social Security insurance programs, Congress in 1974 established the Supplemental Security Income (SSI) program for low income people who are over 65, blind or disabled. 42 U.S.C. § 1381. Congress extended SSI to poor disabled children in the "belief that disabled children who live in low-income households are certainly among the most disadvantaged of all Americans and that they are deserving of special assistance in order to help them become self-supporting members of our society." 1/

An adult is disabled under SSI if he or she "is unable to engage in any substantial gainful activity (SGA) by reason of any

1/ H. R. Rep. No. 231, 92d Cong., 1st Sess. (1971), reprinted in 1972 U.S. Code, Cong. & Admin. News, 4989, 5133.

medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 1382c(a)(3)(A). A child is disabled for purposes of SSI "if he [or she] suffers from any medically determinable physical or mental impairment of comparable severity [to an adult]." Id. (emphasis added). Although Congress did not go further to define the "comparable severity" standard, a similar mandate of Congress conferring "comparable" benefits has been interpreted by this Court to require services or benefits that are not "inferior" and that insure an "equaliz[ing of] the level and quality of services." 2/

Additionally, statutory mandates insuring a methodology for the full evaluation of disability were made applicable to claims for children's as well as adults' benefits. Thus, Congress has required that in determining whether children are disabled, the Secretary "shall" consider the combined effect of all . . . impairments . . . throughout the disability determination process." 42 U.S.C. § 1382c(a)(3)(G). In enacting this requirement, Congress intended that the "total effect" of all impairments be considered by the Secretary. H.R. Rep. No. 618, 98th Cong., 2d Sess. 14 (1984) reprinted in, 1984 U.S. Code, Cong. & Admin. News, 3051-52. Similarly, Congress has mandated that "the Secretary shall consider all evidence available in [the claimant's] case record . . ." 42 U.S.C. §§ 423(d)(5)(B) (Supp. 1988), 1382c(a)(3)(H) (Supp. 1988).

2/ E.g., Wheeler v. Barbara, 417 U.S. 402, 422 n. 17, 425 (1974) (services for educationally deprived children).

Regulatory Scheme

2. Despite the "comparable severity" provision, the Secretary has established two markedly different regulatory tests to measure the disabling severity of the impairments of adult and child claimants. This very disparate treatment both in methodology and strictness of standard is at the heart of this case.

Under the SSI program, adults are evaluated using a five-step sequential evaluation process. 20 C.F.R. § 416.920; Bowen v. Yuckert, 107 S. Ct. 2287, 2290-91 (1987). If not screened out at steps one or two, an adult may prove disability by showing that he or she meets or equals a listed impairment, Heckler v. Campbell, 461 U.S. 458, 460 (1983). Such claimants are considered by the Secretary to be so severely impaired that they are deemed incapable of "any gainful activity." 20 C.F.R. § 416.925(a) (emphasis added). Included on the "Listings" are only impairments considered so severe that benefits are awarded without further inquiry into the claimant's medical limitations and vocational characteristics. Campbell, at 460. The Listings are defined in narrow terms of clinical medical evidence and do not purport to include all impairments that may be disabling. Claimants who do not satisfy the precise requirements of a listed impairment can be found disabled at step three if their impairments are considered "medically equal" to one of those on the list. In determining medical equivalence, however, the Secretary refuses to look at the overall functional consequences of impairments and, instead, confines his inquiry to matching precise clinical findings with those on his Listing. Social Security Ruling (SSR) 83-19.

If the adult's impairment does not meet or equal a listing, the Secretary then "must assess each claimant's individual abilities," Campbell, at 467, including whether he retains the capacity to pursue less demanding work based upon all medical and functional factors including "limitations that go beyond the symptoms that are important in the diagnosis and treatment of [the] medical condition," 20 C.F.R. § 416.945(a), as well as age, education and work experience. ^{3/} Such an individualized assessment allows for an appropriately flexible approach for situations that defy rigid compartmentalization. For example, it allows for decisions to be made for 1) claimants with multiple, combined impairments; 2) claimants with unlisted impairments; and 3) claimants with impairments whose symptomatology does not exactly match all of the elements or required proofs of a particular listing or who suffered from pain or other limiting symptoms.

^{3/} Campbell, 461 U.S. at 460-61, 467. See 20 C.F.R. §§ 416.920(a) and (f), 416.945. Through this "residual functional capacity" (RFC) assessment, the Secretary determines whether the adult can perform his or her relevant past work or, given the claimant's age, education and work experience, and medical condition, whether he or she can perform other work in the national economy. Id.

Although RFC is a "medical assessment" of what the claimant "can still do despite [his or her] limitations," 20 C.F.R. § 416.945(a), it broadly encompasses one's basic physical and mental functioning, § 416.945(b) and (c), embracing descriptions of limitations "that go beyond the [medical] symptoms," § 416.945(a), and from both medical and non-medical sources. SSA, Program Operations Manual System (POMS), DI 2097. See Marcus v. Bowen, 696 F. Supp. 364, 371-72 (N.D. Ill. 1988).

Children, on the other hand, are narrowly limited to an evaluation of whether they meet or equal the listings of impairments. 20 C.F.R. §§ 416.924(b)(2) and (3), 416.925. 4/ A realistic, "individualized determination" of the level of severity of a child's combined impairments, based on an assessment of the child's impaired functioning, is precluded by the sole reliance on the listings. The Secretary acknowledged that his child listings "interpret[ed] severity [of disability] in medical rather than functional terms." 42 Fed. Reg. at 14,706, ¶ 2 (1977). Despite the fact that residual functional capacity (RFC) evaluations are "medical assessments" of severity of disability, note 3, supra, RFC determinations for children are clearly prohibited. 20 C.F.R. § 416.920a(c)(3). 5/

3. Listings provide an efficient administrative tool to award benefits quickly based on a "conclusive presumption" of disability, Bowen v. City of New York, 106 S. Ct. 2022, 2025 (1986), "without further inquiry" into the complete impact of the disabling impairments. Campbell, 461 U.S. at 460. See also Yuckert, 107 S. Ct. at

4/ Child listings are published as Part B to Appendix 1 of the regulations. 20 C.F.R., Part 404, subpt. P. However, the Part A adult listings also apply to children, as the Secretary requires that Part B applies only where Part A criteria "do not give appropriate consideration to the particular disease process in childhood." Preamble to Part B, 20 C.F.R., Part 404, subpt. P, App. 1.

5/ Functional impact indicators of childhood disability such as the need for special education or physical rehabilitation were explicitly "not considered" in the child listings. 42 Fed. Reg. at 14,706 (1977). Thus, the listings on their face preclude the "functional approach to determining the effects of medical impairments," which the Social Security Act contemplates. Yuckert, 107 S. Ct. at 2293.

2297. However, the Listings are not a complete compendium of disabling impairments. As SSA admitted promulgating the Part B Listing, the Listing only provides for an evaluation of "the more common impairments." 42 Fed. Reg. at 14,706, ¶ 4 (1977). See also 50 Fed. Reg. at 50,068, 50,069 (1985) (Part A Listing includes only "frequently diagnosed" conditions). As a consequence, the court below recognized that the discrete and limited child listings "identify only some comparable impairments," Zebley, 855 F.2d at 73-74 (cert. pet. 11a-13a). Although a few of the childhood listings incorporate some functional criteria, the childhood listings "do not cover the entire gambit of disabling childhood medical conditions, [n]or is there any evidence that they can determine the combined effect of separate impairments." Marcus v. Bowen, 696 F. Supp. 364, 381 (N.D. Ill. 1988). 5a/ The latter is so because the listings are defined in terms of single impairments and do not provide a basis for aggregating the effect of disparate impairments. See p. 12, n. 11, infra.

Not only are the childhood listings incomplete and incapable of determining the effects of multiple impairments, but they were intentionally drafted so that a claimant's condition does not meet or equal a listing unless the impairments "are considered severe enough to prevent a person from doing any gainful activity."

5a/ Marcus provides the most detailed historical review of the drafting and regulatory use of listings by the Secretary. Id. at 373-76. Marcus concluded that the government always "understood [listings] medical criteria to be a tool in the efficient administration of the disability program by screening for clearly disabled individuals - not as the dispositive step for persons who otherwise might be unable to engage in gainful activity." Id. at 373-74.

20 C.F.R. § 416.925 (emphasis added). See City of New York, 106 S. Ct. at 2025 (listings acknowledged by Secretary "to be of sufficient severity to preclude gainful employment" not merely substantial gainful activity). 6/ Adults who do not meet a listing receive an assessment of their residual functional capacity and may still be found disabled. Children who do not meet a listing are conclusively ineligible. The Secretary is therefore requiring children under 18 to have impairments of greater severity than those of adults in order to receive benefits. 7/

Individualized RFC Medical Assessment

4. The individualized determination which adult claimants receive after the listings stage of the evaluation process includes a medical appraisal of broad functional capacities in a vocational setting. 8/ This is much more individualized than comparison of each impairment to the listings, but it is still part of the "medical assessment." 20 C.F.R. § 416.945(a) (emphasis added). It is not part of the evaluation of the statutory vocational factors of age, education and work experience. This "residual functional capacity" (RFC) assessment provides a realistic, individualized determination of the

6/ The ability to engage in "any gainful activity" is the statutory test for disabled widow's benefits, 42 U.S.C. § 423(d)(2)(B). By comparison, the lower statutory threshold for SSI is the inability "to engage in any substantial gainful activity." 42 U.S.C. § 1382c(a)(3)(A) (emphasis added). Tolany v. Heckler, 756 F.2d 268, 269-70 (2d Cir. 1985).

7/ Hernandez v. Bowen, No. C-87-582-JBH (E.D. Wash. July 21, 1988), p. 9.

8/ 20 C.F.R. § 416.945(a); Social Security Ruling 83-10.

level of severity of the medical impairment by looking at the basic physical and mental capacities of the individual, separate and apart from an evaluation of the explicit vocational factors detailed in the Act, 42 U.S.C. § 1382c(a)(3)(B), to determine the extent of the claimant's actual ability to work. 9/

Absent an RFC-type medical assessment, the Secretary never fully measures or considers the extent to which claimants for children's benefits are disabled. The Secretary's exclusive reliance on an incomplete, rigid checklist of impairments prevents consideration of the vagaries of individual circumstances, including the variable course of disease and affliction and the cumulative impact of different impairments. Contrary to the Secretary's claims, the court below did not require consideration of "vocational" factors applicable to adult claimants, only a full evaluation of the consequences of impairments on the ability of children to function. 855 F.2d at 73, 76 (cert. pet. at 11a-12a, 17a). Given the fact that some of the Secretary's Listings do encompass functional considerations, and his admission that RFC is a "medical assessment," 20 C.F.R. § 416.945(a), his argument that evaluation of functional effects is tantamount to vocational assessment is disingenuous.

9/ For a detailed analysis of this distinction and its obfuscation by the government in similar litigation, see Marcus, 696 F. Supp. at 372, 380-81. The distinction is significant because the Secretary discusses RFC as only a vocational factors analysis. In a similar vein, he presents the question here as if the Third Circuit had required him to incorporate vocational factors in the child disability process (cert. pet. at 12, 14-15). However, a medical determination of the functional capacities of a child would, under the Secretary's own RFC rationale, operate quite separately from the evaluation of purely vocational factors. See Marcus, at 372, 380-81.

Named and Intervening Plaintiffs and Amici Curiae

5. The named and intervening child-claimant plaintiffs, representing a certified class of other denied child-applicants or terminated beneficiaries (cert. pet. 6a), all illustrate the inflexible limitations of the listings and the markedly disparate treatment child claimants receive:

a) Brian Zebley, brain damaged at birth in 1978, suffered from congenital brain damage with spastic right hemiparesis, mental retardation, developmental delay, eye problems and musculoskeletal impairments and paralysis on his right side (cert. pet. 5a). Although Brian was initially awarded SSI at age 2 upon a finding that he met the mental retardation listing, he was terminated less than two years later on the grounds that he "no longer met or equalled the requirements of any section of the Listings of Impairments at Appendix 1" (*id.*). The Secretary found at an administrative hearing that "Brian Zebley has significant limitations compared with other children of his age," including very limited gross motor skills, spasticity and incoordination; misjudging of distances and frequent falling; and gross motor, self-help, and perceptual/fine motor skills were at or below 50 % of a normal child. ^{10/} Yet, because the Secretary adhered literally and inflexibly to the numerical developmental delay requirements of one child listing (mental retardation), and refused to make a broader, individualized assessment of

^{10/} (Jt. App. 26-27) (emphasis added). References are to the Joint Appendix filed with the Court of Appeals below.

impact of the brain damage on the overall functional limitations of this four year old's life, Brian's benefits were terminated. 11/

b) Joseph Love, Jr. was 10 years old in 1983 when he was denied SSI benefits despite uncontradicted evidence of organic brain syndrome manifested by psychiatric and neurological impairments, including a severe adjustment disorder with mixed emotional and behavioral disturbances and hyperkinesis. (Jt. App. 33, 36). 12/ Joseph failed first grade three times and could not even adapt to alternative special education classes, necessitating home-bound instruction. (Jt. App. 32). At the time of the ALJ hearing, this 10 year old was functioning on a kindergarten academic level although he had been in school for four years. (Jt. App. 34). Educational failures had left him with "severe emotional stress." Id.

11/ The mental retardation listing requires a delay in all developmental skills of no more than one half of the child's age. 20 C.F.R. Part 404, Subpart P, App. 1, § 112.05(A). At 48 months of age, although Brian showed developmental delay in all skills, and delay in gross motor and self-help skills as great or more than one-half his age, Brian's development of non-motor skills, like cognition and language, put him in the 36-42 month range. (Jt. App. at 26). The Secretary finds that a listing is met "only when [an impairment] manifests the specific findings described in the set of medical criteria for that listed impairment. A finding that an impairment meets the listing will not be justified on the basis of a diagnosis [such as congenital brain damage or mental retardation] alone." SSA, POMS, DI 2109.B (Jt. App. 90).

12/ Joseph also was diagnosed as suffering from an attention deficit disorder secondary to family stress and found "unable to relate with his peers, control his aggressions easily or learn." (Jt. App. 36). He went to sleep at 2:00 a.m., woke at 6:00 a.m., was unable to sit still, and constantly was climbing on top of things, sliding across the floor, running up and down steps, getting upset easily, and becoming depressed. (Jt. App. 32).

Because Joseph could undertake some "self-care" activities (such as washing the dishes "occasionally") (Jt. App. 32), he did not meet all four of the "listed" criteria for childhood psychosis or non-psychotic disorders (see App. 1, Part B to 20 C.F.R. Pt. 404, Subpt. P, §§ 112.03, 112.04, Jt. App. 180(a)). ^{13/} Thus, since the individualized medical evaluation of functional impairment available to adults was precluded for Joseph, ^{14/} the Secretary denied benefits to an extremely maladjusted and emotionally disturbed ten year old who suffered from organic brain syndrome and a severe adjustment disorder.

A psychiatric consultant in the Secretary's national Office of Disability with twenty years of experience, Dr. Jerome Shapiro, admitted that Joseph Love, Jr.'s symptoms appear "often" in both children and adults, and while he acknowledged that an adult with such symptoms could be found disabled by an individualized

^{13/} The relevant child mental disorder listings, "Psychosis of infancy and childhood" and "Functional nonpsychotic disorders," both require "marked restriction in the performance of daily age-appropriate activities; constriction of age-appropriate interests; deficiency of age-appropriate self-care skills; and impaired ability to relate to others" Part B, §§ 112.03 and 112.04 (emphasis added).

^{14/} The Secretary has issued a Social Security Ruling, SSR 85-16, to emphasize the "importance" and flexibility offered by an RFC assessment of an adult's mental disorder when the disorder does not meet or equal a listing. The Ruling, which specifically excludes "children under 18," requires a broad "overall assessment of the effects of the mental impairment" including evidence from social workers and family members in "assessing an individual's level of activities of daily living." SSR 85-16 (West's Soc. Sec. Rptng. Serv. pp. 424-28, Supp. Pmpht. 1988) (Jt. App. 194). See also 20 C.F.R. § 416.920a(c)(3) quoted on p. 3, supra.

assessment of residual functional capacity, a child with the "identical" symptomatology (who, like the adult, did not meet or equal the listings) would never be found disabled. (Jt. App. 71-74).

c) Evelyn Raushi was born mentally retarded in 1974, and was determined disabled upon meeting the listings beginning in 1979, but her benefits were subsequently terminated as of October, 1981 when the Secretary determined that her condition did not meet any listed impairment. (Jt. App. 42). Evelyn had an I.Q. of 64 and tests given by the Secretary's consultative psychologist also revealed "emotional immaturity and intellectual and social impoverishment consistent with [her] development delay"; "significant latent anxiety"; and, in addition to mental retardation, diagnoses of "developmental learning disorder", and "minimal brain dysfunction." (Jt. App. 44-45).

Although the Secretary found that Evelyn had suffered from mental retardation with an I.Q. in the 60-69 range, the evidence did not establish that she also suffered from a "significant impairment" other than the mental retardation. Thus, the Secretary concluded that the girl did not "meet or equal" the mental retardation listing, Section 112.05(C) of Part B of the listings. (Jt. App. 45-46). 15/ The Secretary's policies thus totally precluded the more flexible, individualized evaluation of this mentally retarded and

15/ This mental disorder listing requires that a child diagnosed as impaired by mental retardation with an IQ between 60 and 69 must also show a "physical or other mental impairment imposing additional and significant restriction of function or developmental progression." 20 C.F.R. Pt. 404, subpt. P, App. 1, § 112.05(C).

emotionally disturbed girl's overall functioning. An adult would have received such consideration. 16/

d) Three separate amicus briefs filed below on behalf of over two dozen disability and children's organizations nationally further established that class members include severely disabled children with such impairments as spina bifida, Tourette Syndrome, Down's Syndrome, microcephaly and Prader-Willi Syndrome who have been "routinely rejected for SSI under the listings criteria." (Am. Br. of Pa. Protection & Advocacy, Inc. at 1-3, 20). An amicus brief submitted by the Spina Bifida Association of Greater Los Angeles, et al., points out that many of the functional limitations of children suffering from spina bifida, such as gastrostomy tubes, tracheostomies and shunts from the brain, are not even recognized in the listings, resulting in such children being denied SSI. (Am. Br. at 2 as cited in 855 F.2d at 72-73 (cert. pet. 10a)).

Lower Court Decisions

6. The district court on October 12, 1984 granted Brian Zebley's motion for partial summary judgment, ordering payment of benefits and remanding for their calculation. (cert. pet. 6a). On March 13, 1985 and April 23, 1987 the court also remanded the claims of Evelyn Raushi and Joseph Love, Jr., respectively. (Id.) However, the court granted the Secretary's motion for summary judgment, dismissing the class claims. While noting that "[p]laintiffs' argument [as to the inadequacy of the listings test] may well be valid," the

16/ See Social Security Ruling 85-16, note 14, p. 13, supra.

court was not prepared to find the Secretary's overall policy invalid. (Id. at 249).

7. Following plaintiffs' appeal to the Court of Appeals for the Third Circuit, the unanimous court found the child regulations to be "inconsistent with the statute in precluding a finding that a child is disabled unless his impairment meets or equals a listed one." (cert. pet. 12a). The court determined that, "Congress has expressed unambiguously its intent that 'any' impairment which meets the statutory standard shall be found disabling. Therefore, the Secretary's regulatory method for determining disability must be adequate to identify any qualifying impairment." (id. at 11a) (emphasis in original). The court reasoned that the listings, designed to reveal the most severely disabled claimants for quick, presumptive awards, "do not purport to be an exhaustive compilation of medical conditions which could impair functioning to the extent necessary to satisfy the statutory standard for disability," yet only adults are given the further opportunity to establish eligibility through an "individualized assessment of the actual degree of functional impairments" (id. at 11a-12a) (emphasis in original). Because it was the expressed intention of Congress to allow children to show they suffered from "any" impairment of "comparable severity" to one "which would actually, even if not presumptively [via the listings], disable an adult," the Secretary's regulatory method identifying "only some comparable impairments" was held to be inadequate. (id. at 12a-13a) (emphasis in original).

The Secretary appeals from this decision of the Third Circuit which by its terms does not set forth any relief for the class.

Introduction

The Secretary has misrepresented the Third Circuit's decision as presenting the question of requiring analogous consideration of vocational factors, the specific approach rejected by Powell v. Schweiker, 688 F.2d 1357 (11th Cir. 1982) and Hinckley v. Secretary of HHS, 742 F.2d 19 (1st Cir. 1984). Rather, the decision in Zebley requires for disabled children "an opportunity for individualized assessment of their functional limitations" (855 F.2d at 77; cert. pet. 20a), an evaluation fully in accord with the Social Security Act and prior decisions of this Court. Such a holding ensures a consideration of the severity of all a child's impairments, not just those in the listings. There is thus no conflict with the Hinckley and Powell decisions because the Third Circuit did not mandate consideration of vocational factors. And because the actual holding of the Third Circuit is so clearly correct, this Court's review of that decision is not warranted.

I. THERE IS NO CONFLICT BETWEEN THE COURT OF APPEALS DECISION BELOW AND THE DECISIONS OF THE FIRST AND ELEVENTH CIRCUITS

The decision of the Third Circuit poses no conflict to Powell and Hinckley and, rather, is in accord with the uniform line of cases that have, in the adult setting, held that sole reliance on the listed impairment standard is too restrictive under the Act. ^{17/} The

^{17/} See, e.g., Lewis v. Weinberger, 541 F.2d 417, 420 (4th Cir. 1976); Whitt v. Gardner, 389 F.2d 906, 910 (6th Cir. 1968); Murphy v. Gardner, 379 F.2d 1, 8 (8th Cir. 1967). Cf. Bowen

Hinckley and Powell courts each read the single plaintiff's claims as urging adoption for disabled child cases of vocational criteria similar to the adult work test criteria. For example, the district court in Powell viewed plaintiff's challenge as going to "the Secretary's failure to use factors comparable to vocational factors for adults" 688 F.2d at 1359, n. 5. ^{18/} Both courts upheld the child regulations, finding that Congress did not require application of vocational factors to child SSI claims or an inquiry into whether a child claimant could work were he an adult. ^{19/} But as the Marcus court recently observed, "Powell and Hinckley did not address the inadequacies of the Listings Th[ese] decisions are relevant insofar as they hold that Congress did not require application of vocational factors to child SSI claims." 696 F. Supp. at 381. Thus, since the imposition of vocational-type factors was not pursued by Zebley plaintiffs nor adopted by the Third Circuit, which did address

^{18/} See also Hinckley, 742 F.2d at 23 (plaintiff's urging non-medical criteria to be applied in the setting of a "vocational factors' test").

^{19/} The Powell court relied on a post-enactment Senate Finance Committee Staff Report explaining why "nonmedical vocational factors were not applied." 688 F.2d at 1362. Similarly, Hinckley relied on legislative history to hold that the "substantial gainful activity" standard was inappropriate as well as any inquiry by the Secretary as to "whether the [child] could work were he an adult." 742 F.2d at 23.

the listings' inadequacies, there is no conflict with the First and Eleventh Circuit decisions. 20/

Further, the Hinckley court assumed, 742 F.2d at 23, as the Secretary emphasizes in his certiorari petition at 12, that individualized assessments are provided by allowing children to prove that their impairments are medically equivalent to a Part B listed childhood impairment. See 20 C.F.R. § 416.926(b). Yet the Hinckley court never was presented with the Secretary's policy in Social Security Ruling 83-19 on equivalency determinations which totally precludes consideration of the functional consequences of impairments: "[I]t is incorrect to consider whether the listing is equaled on the basis of an assessment of overall functional impairment . . . The functional consequences of the impairments . . . irrespective of their nature or extent, cannot justify a determination of equivalence." SSR 83-19 (emphasis in original). Since "[i]t is only impaired ability to function which results in disability," Zebley, 855 F.2d at 74, these determinative factors in any disability are foreclosed in the Secretary's equivalency determinations. Equivalency policy thus is a source of unfairness in the Secretary's methodology rather

20/ The fact that the Zebley court said it was not following Powell and Hinckley does not change the analysis, as it is what Zebley held as against what these other two courts held which is decisive for purposes of determining whether a conflict exists requiring this Court's resolution. Apparent conflicts of decisions may disappear upon closer analysis. See Stern & Gressman, Supreme Court Practice, sec. 5.15, p. 370 (5th ed. 1978). "There must be a real conflict on the same matter of law or fact, not merely an inconsistency in dicta or in the general principles utilized." Id. sec. 4.3, p. 264. Only through the Secretary's misstatement of the issue here is a split in the circuits manufactured.

than providing the flexibility the Hinckley court erroneously assumed. See Zebley, at 74 (cert. pet. 13a). 21/

Moreover, equivalency determinations are still circumscribed by the relevant childhood listings in Part B of Appendix 1 of the regulations. The Secretary has admitted that these childhood listings "are based on the concept of 'comparable severity' to the [adult Part A] Listing of Impairments published in the appendix [for Title II wage-earners]," 42 Fed. Reg. 14705 (1977), and not comparable to the statutory substantial gainful activity standard. 22/ Thus, whatever breadth the equivalency determination may have, it cannot extend beyond the severity levels set by the listings which the Secretary deems higher than that set forth in the statute. See pp. 8-9, supra.

Finally both Powell and Hinckley were decided before Congress codified the mandates that "the Secretary shall consider the combined effect of all of the individual's impairments . . . throughout the disability determination process," Sec. 4(b) of the Social

21/ See also Marcus, 696 F. Supp. at 372-73, 378-79. The restrictive medical equivalence policies of SSR 83-19, becoming effective in 1980, resulted in a major drop in equivalence allowances from 45.1 % in 1976 to 8.7 % in 1984. House Committee on Ways and Means, WMCP 99-14, "Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means," 99th Cong., 2d Sess., p. 114, Table 2 (March 3, 1986). The record in this case also establishes via deposition of the Secretary's medical compliance review officer, Dr. Maurice Prout, that equivalence decisions are "hardly ever utilized in mental cases." (Jt. App. 62).

22/ The Secretary's listings regulation, 20 C.F.R. § 416.925(a) makes it clear that its purpose is to establish a higher severity threshold than is in the statute. See note 6, supra and City of New York, 106 S. Ct. at 2025.

Security Disability Benefits Reform Act of 1984, Pub. L. 98-460, 98 Stat. 1800, 23/ and that "the Secretary shall consider all the evidence [of disability] available in such individual's case record" Sec. 9(b)(1) of the Reform Act, 98 Stat. 1805. 24/

The Reform Act notwithstanding, myriad restrictive and inflexible policies preclude an evaluation of the functional impact of the "combined effect" of impairments and of "all the evidence" of disabling limitations at the "meet or equal" listings step, see, e.g., 42 Fed. Reg. 14705 (1977); SSR 83-19. 25/ "By the Secretary's own admissions, it is clear that the Listings . . . do not measure the combined effect and impact of the claimant's impairments" Marcus, 696 F. Supp. at 378.

The only method now available to the Secretary to consider these "combined effect" policy and "all evidence" mandates is the residual functional capacity assessment, an evaluation available only to adults. See 20 C.F.R. § 416.920a(c)(3). Zebley is fully in accord with these new statutory directions by requiring an individualized determination of the degree of functional incapacitation

23/ 42 U.S.C. § 1382e(a)(3)(G) (Supp. 1988). This mandated consideration of the combined effect and impact of impairments is in accord with the prior established congressional intent that each claimant's functional limitations be individually and realistically assessed. See Yuckert, 107 S. Ct. at 2293, 2304.

24/ 42 U.S.C. §§ 1382e(a)(3)(H) (Supp. 1988), 423(b)(5)(B) (Supp. 1988).

25/ The Secretary "has refused to give claimants under 18 an opportunity to prove disability based upon consideration of 'all the pertinent facts.'" Powell, 688 F.2d at 1364 (dissent) (pre-Reform Act holding).

during this additional evaluative step. 855 F.2d at 76, 77 (cert. pet. 18a, 20a). Powell and Hinckley predate the Reform Act and should not be considered good law on this important point.

II. THE DECISION OF THE COURT OF APPEALS
BELOW IS SO CLEARLY CORRECT THAT THIS
COURT'S REVIEW OF THAT DECISION IS NOT
WARRANTED

Congress never intended that the methodology utilized by the Secretary be one to preclude a full evaluation of disability or that a markedly stricter severity of disability standard be imposed through sole reliance on listings of impairments. 26/ No deference is due the agency's interpretation of a standard inconsistent with congressional intent. INS v. Cardoza-Fonseca, 480 U.S. 421 (1987). As such, the Secretary's policy was properly rejected by the court below. Securities Industry Ass'n v. Board of Governors of Federal Reserve System, 468 U.S. 137 (1984). Through the children's "comparable severity" provision of 42 U.S.C. § 1382c(a)(3)(A), Congress explicitly ordered that the same or equivalent adult level of severity of disability be established for the evaluation and award

26/ In establishing the SSI disability program Congress stressed a uniformity of approach in methods and standards by providing that the "definition of disability . . . used in the disability insurance program [42 U.S.C. § 423(d)(1)(A)] . . . would be generally applicable to disabled in the SSI program." H.R. Rep. No. 231, 92d Cong., 2d Sess. reprinted in 1972 U.S. Code, Cong. & Admin. News at 5233. See City of New York, 106 S. Ct. at 2024.

of benefits to children. 27/ A comparability requirement in a federal benefits statute requires an "equaliz[ing of] the level and quality of services." Wheeler, 417 U.S. at 425.

In addition, this Court has repeatedly viewed the Title II (disability insurance) and Title XVI (SSI disability) programs as having two prime thrusts: The first is that our disability law demands no less than a "functional approach to determining the effects of medical impairments." Yuckert, 107 S. Ct. at 2293 (majority op.) and 2304 (dissenting op.). The second is that the statute contemplates "individualized determinations" of these functional limitations which "assess each claimant's individual activities." Campbell, 461 U.S. at 467. As a consequence, the Secretary's analogous reliance solely on the mental disorder listings to determine whether mental impairments can be disabling has been rejected in favor of a "'realistic, individual assessment of each claimant's ability to engage in substantial gainful activity.'" City of New York, 106 S. Ct. at 2027 and n. 5.

The listings of impairments were never designed to provide the complete, individualized determinations of all functional limitations. 42 Fed. Reg. 14,705 (1977). The role of the listings in the disability evaluation process was intended to "streamline the decision process by identifying claimant" with the most severe medical

27/ 1972 U.S. Code, Cong. & Admin. News at 5134. Such equal treatment furthered the basic goal of establishing a uniform disability standard for all recipients of the new SSI program. See also 117 Cong. Rec. 21089 (1971) (floor statement of Rep. Wilbur Mills, Chairman, House Committee of Ways and Means).

impairments, Yuckert, 107 S. Ct. at 2287, and to allow an award of benefits quickly, based on a "conclusive presumption" of disability. City of New York, 106 S. Ct. at 2025.

Thus, in promulgating the Part A listings, the Secretary admitted that the list is incomplete and only contains impairments which occur frequently. 50 Fed. Reg. at 50069 (1985). Similarly, in promulgating the Part B listings applicable to children, he stated that the methodology listings provide "a means to efficiently and equitably evaluate the more common impairments." 43-Fed. Reg. at 14,706 (1977). These gaps in the listings are not closed by the inclusion of a "medical equivalence" assessment because, as noted above at p. 19, the Secretary has effectively eviscerated this assessment by forbidding his adjudicators to find a listed impairment "equalled" on the basis of the functional consequences of a claimant's impairments. SSR 83-19. In sum, children whose impairments are not listed, are not given a meaningful chance to prove that their impairments are of "comparable severity", and are denied benefits even though they may be as disabled, or more disabled, than children with listed impairments.

Moreover, the Secretary has been under an explicit statutory duty imposed by the 1984 Social Security Disability Benefits Reform Act, Pub. L. 98-460, Sections 4(b) and 9(b) to "consider the combined effect of all of the individual's impairments . . . throughout the disability determination process," and "to consider all the evidence [of disability]." 42 U.S.C. §§ 1382c(a)(3)(G) and (H) (Supp. 1988) at p. 2, supra. Most severely disabled child claimants, such

as Brian Zebley and Joseph Love, Jr. here, have multiple impairments, see pp. 11-14, supra. Yet, there is no way by which this "combined effect" evaluation can be accomplished within the listings without a further individualized assessment of functional limitations comparable to the RFC assessment, see 20 C.F.R. § 416.945(d), which adults receive. 28/

Thus, the Third Circuit was fully correct in its conclusion that the discrete and narrow childhood listings "identify only some comparable impairments." 855 F.2d at 73-74 (cert. pet. 11a-13a). See also Marcus, 696 F. Supp. at 378, 381.

In addition to not fully assessing the severity of children's impairments, the Secretary, by sole reliance on the listings for evaluation of children, has established a standard of severity that is more strict than that applied to adult claimants. The Part A adult listings are defined to include impairments that are so severe as to preclude performance of "any gainful activity," 20 C.F.R. § 416.925(a), a stricter standard than the statutory "any substantial gainful activity" test. 42 U.S.C. § 1382c(a)(3)(A) (emphasis added). 29/ The Part B childhood listings also embody this heightened test. As the Secretary stated in promulgating the Part B [adult] listings, its criteria "are based on 'comparable severity'

28/ Marcus, 696 F. Supp. at 378, 381 (Secretary admits and there is no evidence that the Secretary can determine through the listings the combined effect of separate impairments).

29/ See City of New York, 106 S. Ct. at 2025 ("The listings consist of specified impairments acknowledged by the Secretary to be of sufficient severity to preclude gainful employment.").

to the Listing of Impairments" and that when a child reaches age 18, he or she could be expected to satisfy the criteria of the Part A Listing. 43 Fed. Reg. 14,705 (1977). This "any gainful activity" standard is, on its face, higher than, not comparable to, the statutory SSI standard for adults of inability to "engage in any substantial gainful activity." 30/

Not only do the listings set a severity threshold higher than the statute provides for, but, as the Secretary also admitted when he first promulgated the Part B childhood listings, they "interpret severity [of disability] in medical rather than functional terms." 42 Fed. Reg. at 14,705. Indicators of functional impact, such as Joseph Love's failing first grade three times and being unable to sustain himself in a special education class for mentally disturbed children, supra at 12, were explicitly excluded from the childhood listings. 42 Fed. Reg. at 14,706 (needs for "special education

30/ In the widow's disability insurance program Congress did legislate the stricter disability standard of inability to engage in "any gainful activity" as opposed to the SSI program's "any substantial gainful activity." 42 U.S.C. § 423(d)(2)(A). Yet despite the Secretary promulgating a disability evaluation for widow's, like for children, based solely on the listings of impairments, 20 C.F.R. § 404.1578, courts have held that even with a heightened statutory severity standard, the Secretary cannot fail to evaluate all evidence of functional impairment to get a realistic view of the severity of the impairment or to measure the combined impact of multiple impairments. E.g., Tolany v. Heckler, 756 F.2d 268, 272 (2d Cir. 1985); Paris v. Schweiker, 674 F.2d 707, 710 (8th Cir. 1982); Marcus v. Bowen, 696 F. Supp. 364, 379 (N.D. Ill. 1988).

. . . are not included"). 31/ By reading out the consideration of functional impairment from his medical inquiry of "severity" of impairment, the Secretary has contravened the Act which "defines 'disability' in terms of the effect a physical or mental impairment has on person's ability to function" Campbell, 461 U.S. at 459-60 (emphasis added). See also Yuckert, 107 S. Ct. at 2293 (Act's "functional approach to determining the effects of medical impairments"). 32/

The Secretary has failed to demonstrate that Congress ever ratified or approved his use of the listings as the sole test for the children's program. See Comm'r of Internal Revenue v. Glenshaw Glass Co., 348 U.S. 426, 431-32 (1955); Assoc. of American R.R. v. ICC, 564 F.2d 486, 493 (D.C. 1977). 33/ The only congressional

31/ The Secretary's certiorari petition admits as much in its circumspect representation that only "some of the Secretary's listings in Part B specifically call for a general assessment of a child's functional capacity" (p. 12) (emphasis added).

32/ Yuckert construed the term "severity" and addressed itself to how severity is measured. This case requires interpretation of the same term in the same statutory sentence dealt with in Yuckert. The question here is not only what does "comparable" mean, but what does "severity" mean in the context of a disability program as one cannot determine whether impairments are "comparable" unless one measures how severe they are. This Court's basis for upholding the severity regulation in Yuckert was that the regulation embodied a medical inquiry into the degree of functional impairment. 107 S. Ct. at 2293. This is in direct conflict with the children's disability policy that consideration of function is not part of medical severity.

33/ This Court, in upholding the "severity" regulation in the Secretary's sequential evaluation process, relied upon explicit "expression of approval" of it by Congress and legislative history "expressly endors[ing] the severity regulation." Yuckert, 107 S. Ct. at 2294-97.

statement cited by the Secretary is the provision that SSA publish children's listing "criteria," Unemployment Compensation Amendments of 1976, Pub. L. No. 94-566, 90 Stat. 2685. Yet there is no evidence of any intent that these criteria were intended to be the only test employed. This 1976 enactment is explained by the fact that the Secretary, four years after the enactment of the children's SSI program, had been "extraordinarily slow" in developing any guidelines similar to the adults listings, and although "draft regulations with criteria" were circulating, Congress determined that uniformity required their prompt promulgation. Sen. Rep. No. 1265, 94th Cong., 2d Sess., 24-25, as reprinted in 1976 U.S. Code, Cong. & Admin. News 5997, 6018-19.

It is true that the floor statements of Senators Bentsen and Hathaway reflect that "vocational ability" was not intended to be considered involving children's disabilities. 122 Cong. Rec. 33301, 34026 (1976). But as Senator Hathaway stated, the children's assessment, "[l]ike the test for determining the disability of an adult," was "not [to be] determined solely on medical grounds" but rather upon "an evaluation of the impact of the disability on the person's abilities." 122 Cong. Rec. 34026 (1976). With such an individualized impact test, the focus, he said, should be on the child's "ability to function successfully within age-appropriate expectations." 34/ Contrary to the Senators' expectations that the

34/ Senator Hathaway continued: "The child's functional capacity within the areas of learning, language, self-help skills, mobility and social skills are decidedly more meaningful in determining both the severity of the impairment and the developmental potential of the child." Id. at 34026.

criteria for children would evaluate functional impacts and would not be "restrictively drawn," 122 Cong. Rec. at 34026, the listings criteria ultimately published "interpret[ed] severity in medical rather than functional terms," as the Secretary explicitly acknowledged. 42 Fed. Reg. 14,705 (1977). 35/

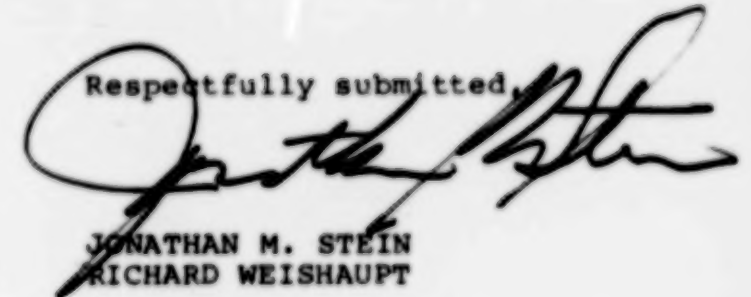
The Third Circuit ordered only that disabled children receive the same type of individualized, realistic assessment of the functional limitations of their impairments as adults, and gave the Secretary considerable leeway to establish appropriate methods of conducting this assessment. It is significant to this Court's certiorari determination that the order appealed from does not provide any relief and that the Secretary's speculative complaints about the scope of relief are not ripe and not before the Court. In light of the absence of any conflict with other circuit decisions (except as created by the Secretary's misstatement of the issue and decision of the Third Circuit), and the soundness of the Zebley decision, this decision should not be reviewed by the Court.

35/ Despite the Secretary's assertion of congressional oversight (cert. pet. at 15, n. 4), in over 15 years there has been virtually no oversight of the children's SSI disability program. Rather than receiving "frequent and intense congressional attention," Schweiker v. Chilicky, 108 S. Ct. 2460 (1980), SSI disabled children claimants have been largely forgotten.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,



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APRIL 20, 1989

No. 88-1377

3

Supreme Court, U.S.

FILED

MAY 15 1989

CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1988

**LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER**

v.

BRIAN ZEBLEY, ET AL.

**ON PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

REPLY BRIEF FOR THE PETITIONER

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14 PP

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In the Supreme Court of the United States

OCTOBER TERM, 1988

No. 88-1377

LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

REPLY BRIEF FOR THE PETITIONER

The court of appeals in this class action invalidated the regulations that have been utilized by the Secretary of Health and Human Services since 1977 to adjudicate claims for child's disability benefits under the Supplemental Security Income (SSI) program established by Title XVI of the Social Security Act, 42 U.S.C. 1381 *et seq.* Those regulations are designed to give specific content to the statutory definition of "disability" for purposes of child's benefits, which provides that a child is disabled if he suffers from an impairment that is of "comparable severity" to an impairment that would render an adult disabled. 42 U.S.C. 1382c(a)(3)(A). Moreover, the principle on which the regulations are based — that a child will be found to be disabled only if his impairment meets or equals a listed impairment — was embodied in the regula-

tions promulgated by the Secretary at the outset of the SSI program in January 1974 and has been the basis for reviewing hundreds of thousands of applications for child's disability benefits since that time.

Because the decision below substantially alters the settled implementation of the child's disability program and conflicts with decisions of the First and Eleventh Circuits upholding the same regulations, review by this Court is clearly warranted. Respondents' arguments to the contrary are without merit.

1. Respondents first take issue (Br. in Opp. 17-22) with our submission (Pet. 15-17) that the decision of the Third Circuit in this case conflicts with *Hinckley v. Secretary of HHS*, 742 F.2d 19 (1st Cir. 1984), and *Powell v. Schweiker*, 688 F.2d 1357 (11th Cir. 1982). The conflict, however, is manifest.

a. In *Powell*, the plaintiffs contended that the regulations are invalid because (i) they assertedly are more restrictive than those applicable to adults, and (ii) they do not provide for an individualized, functionally based determination of disability that parallels the consideration of the vocational factors of age, education and work experience in the case of adult claimants whose impairments do not meet or equal the listings in Appendix 1. See 688 F.2d at 1360, 1362 n.13. These are the same contentions upon which the Third Circuit in the instant case relied in invalidating the regulations. See Pet. App. 11a-12a, 13a, 14a-16a, 17a. The Eleventh Circuit, however, rejected those contentions, concluding that children are not clearly treated more restrictively than adults and that the regulations are based on a reasonable interpretation of the statutory standard that the child's impairment be of "comparable severity." 688 F.2d at 1360-1361.

In *Hinckley*, the First Circuit "join[ed] the Eleventh Circuit in upholding the Secretary's regulations" (742 F.2d at

23). In so doing, it expressly rejected the contention, adopted by the Third Circuit in the instant case (Pet. App. 11a-12a, 17a), that 42 U.S.C. 1382c(a)(3)(A) requires the Secretary to make an individualized consideration of nonmedical criteria—such as the child's age, education, and functional limitations—that is parallel to the consideration of an adult claimant's residual functional capacity (RFC) and his age, education, and work experience. See 742 F.2d at 22-23.

b. Respondents' efforts to explain away the circuit conflict are unavailing. For example, respondents describe *Powell* and *Hinckley* as rejecting only the contention that the Secretary must apply "vocational" criteria in evaluating claims for child's disability benefits. See Br. in Opp. 17-19. However, *Powell* and *Hinckley* did not focus narrowly on the need to consider vocational factors as such. The argument rejected by the First and Eleventh Circuits in those cases was that the Secretary is required by the Act to make an individualized assessment of the functional impact that the impairment has on the child in a manner that is *analogous* to the Secretary's consideration of an adult claimant's RFC, age, education and work experience. See *Powell*, 688 F.2d at 1360, 1361; *Hinckley*, 742 F.2d at 22-23. That is the position adopted by the Third Circuit in this case (Pet. App. 17a) and urged by respondents in defense of the judgment below (Br. in Opp. 23, 26-29).

Respondents also argue (Br. in Opp. 20-22) that the circuit conflict is of no current importance because *Powell* and *Hinckley* were decided prior to the enactment of Sections 4(b) and 9(b)(1) of the Social Security Disability Benefits Reform Act of 1984, 42 U.S.C. 1382c(a)(3)(F) and 423(d)(5)(B) (Supp. IV 1986). Those provisions require the Secretary to consider the combined effect of several impairments at each step of the sequential evalua-

tion process (see *Bowen v. Yuckert*, 482 U.S. 137, 149-152 (1987)) and to consider all the evidence in the claimant's case record. Respondents' reliance on the 1984 Act is misplaced. Section 9(b)(1) does not modify any substantive standards of disability; it is concerned only with the evidence on which a decision under those standards must be made. Section 4(b) likewise lends no support to respondents' position. Even before the 1984 Act was passed, Social Security Ruling (SSR) 83-19 provided that the combined impact of several impairments could be considered in determining whether a claimant's impairments equalled the listings,¹ and that requirement is carried forward under current regulations.² Section 4(b) of the 1984 Act therefore casts no doubt on the Secretary's longstanding approach to evaluating claims for child's disability benefits, and respondents in fact point to no evidence of congressional intent to mandate a change in that approach. In any event, the Eleventh Circuit has expressly adhered to its decision in *Powell* since the 1984 Act was passed (*Wilkinson v. Bowen*, 847 F.2d 660, 661 (11th Cir.

¹ SSR 83-19 provides that equivalency may be found under any of three circumstances, one of which is where the claimant has "a combination of impairments (none of which meet or equal a listed impairment), each manifested by a set of symptoms, signs, and laboratory findings which, combined, are determined to be medically equivalent in medical severity to that listed set to which the combined sets can be most closely related" (SSR 83-19, West Soc. Security Rep'r Serv. (Rulings) 90, 92 (Supp. 1988) (emphasis in original)).

² See 20 C.F.R. 416.923 (stating that the combined effect of multiple impairments will be considered "throughout the disability determination process"); 20 C.F.R. 416.926(a) (explaining the method for determining whether a claimant's "impairment(s) is medically equivalent to a listed impairment"). In light of these regulatory provisions and SSR 83-19, respondents err in contending (Br. in Opp. 8, 21) that the listings do not allow for consideration of the combined effect of multiple impairments.

1987)), thereby refuting respondents' premise that the circuit conflict has been superseded by statute.

c. The circuit conflict that respondents deny was obvious enough to the Third Circuit, which candidly "recognize[d] that [its] decision places [it] in the minority among the courts which considered the legality of these regulations" (Pet. App. 16a). The court below further acknowledged that "[t]he Secretary's arguments on this appeal are essentially those adopted by the courts in *Powell* and *Hinckley*," but it "decline[d] to accept" the "reasoning" and "conclusion" of *Powell* and *Hinckley* (*id.* at 13a), "find[ing] neither decision persuasive" (*id.* at 12a). Similarly, the district court decision upon which respondents principally rely recognizes that the Third Circuit in this case "rejected the reasoning in *Powell* and *Hinckley*" (*Marcus v. Bowen*, 696 F. Supp. 364, 381 (N.D. Ill. 1988)).

d. In short, there is a clear and acknowledged conflict between the decision below on the one hand and *Powell* and *Hinckley* on the other.³ See also *Burnside v. Bowen*, 845 F.2d 587, 590-591 (5th Cir. 1988); *Petroleoni v. Secretary of HHS*, NO. 87-2021 (10th Cir. Oct. 26, 1988). Furthermore, the legal issue is one of broad and recurring

³ The conflict is all the more pronounced to the extent that the class certified by the district court, which apparently is of nationwide scope, includes members in the First and Eleventh Circuits. If nationwide relief is ordered by the district court, the effect of the decision below will be to allow the court of appeals in one circuit to overrule the governing circuit precedent in two other circuits that have sustained the Secretary's regulatory approach. After the court of appeals rendered its decision in this case, the Secretary filed a motion in the district court to exclude from the class any individuals residing in the First and Eleventh Circuits in light of the decisions in *Powell* and *Hinckley*, as well as in other jurisdictions in which decisions approving the regulations have been issued or suits challenging the regulations are pending. The district court has not yet ruled on that motion.

importance in the administration of the SSI program, because the challenged regulations are applied in the adjudication of more than 50,000 claims annually under the SSI program.⁴ The petition for a writ of certiorari therefore should be granted. That course would be consistent with *Heckler v. Campbell* 461 U.S. 458 (1983), and *Yuckert*, in which the Court likewise granted review in light of circuit conflicts on questions of broad importance in the administration of the disability program. See 461 U.S. at 464; 482 U.S. at 145-146.

2. Respondents' defense of the Third Circuit's decision on the merits (Br. in Opp. 22-29) warrants a brief reply.

a. The regulations governing the evaluation of child's disability claims were issued pursuant to the Secretary's general rulemaking authority under 42 U.S.C. 405(a), as augmented by his specific authority under Section 501(b) of the Unemployment Compensation Amendments of 1976, Pub. L. No. 94-566, to "publish criteria to be employed to determine disability (as defined in [42 U.S.C. 1382c(a)(3)(A)]) in the case of persons who have not attained the age of 18" (90 Stat. 2685). "Such legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Chevron U.S.A. Inc. v. NRDC*, 467 U.S. 837, 843-844 (1984). Accord *Campbell*, 461 U.S. at 466; *Yuckert*, 482

⁴ The same legal issue is pending before the Eighth Circuit in *Nash v. Bowen*, No. 88-2512, which is scheduled for oral argument on May 9, 1989, and before the Ninth Circuit in *Burt v. Bowen*, No. 88-3990, which has not yet been scheduled for oral argument. In addition, since the certiorari petition was filed, two other district courts have considered the same issue; one sustained the regulations (*Campbell v. Bowen*, No. 3-88-0592 (M.D. Tenn. Apr. 3, 1989)) and one invalidated them (*Cagle v. Bowen*, No. 88-6069 (W.D. Ark. Apr. 24, 1989)).

U.S. at 145. Respondents have not shown that the regulations at issue here are "manifestly contrary" to the statute. Indeed, as we have shown (Pet. 9-15), the regulations constitute a reasonable implementation of the statutory standard that the severity of a child's impairment be "comparable" (not identical) to an impairment that would render an adult disabled: the regulations provide that a child will be found to be disabled if his impairment meets or equals an impairment contained in the listing of qualifying impairments for adults in Part A of Appendix 1 to the regulations, or if his impairment meets or equals an impairment contained in a *special* listing in Part B of Appendix 1 of additional afflictions that are found primarily in children or that have a particular effect on children.

Contrary to respondents' contention (Br. in Opp. 23, 26-27), the regulations are not divorced from functional considerations. As the Third Circuit acknowledged (Pet. App. 15a-16a), the special listing in Part B contains those impairments that the Secretary determined, after extensive study and consultation with medical experts, to have an impact on a child's development that is comparable to the effect that a disabling impairment has on an adult's ability to engage in substantial gainful activity.⁵

⁵ The preamble to the regulations issued in 1977 stated (42 Fed. Reg. 14,705):

The medical criteria were developed and formulated over a 2-year period by the Social Security Administration Medical Consultant Staff together with practicing physicians, and other professionals, such as psychologists, who are experts in various specialties, primarily pediatrics. In identifying these impairments and the level of severity which would establish disability, these professionals placed primary emphasis on the effects of physical and mental impairments in children, the impact of the impairment on the child's activities, and the restrictions on growth, learning, and development imposed on the child by the im-

b. Respondents' contention that the regulations nevertheless are "inconsistent with congressional intent" (Br. in Opp. 22) ignores both the origins of the Secretary's requirement that an applicant for child's disability benefits must show that his impairment meets or equals the listings and the indicia of congressional approval of that evaluative approach.

On January 11, 1974, the Secretary promulgated regulations governing determinations of disability under the SSI program, which had just gone into effect on January 1, 1974. See 39 Fed. Reg. 1624 (1974). Those regulations provided that a child under age 18 will be deemed disabled if his impairment or impairments are listed in the appendix or, if not listed, they "are determined by the [Social Security] Administration, with appropriate consideration of the particular effect of disease processes in childhood, to be medically the equivalent of a listed impairment" (39 Fed. Reg. 1626, adding 20 C.F.R. 416.904 (1975)). The regulations were promulgated in final form on July 29, 1975. 40 Fed. Reg. 31,778, 31,783. Thus, the evaluative approach that respondents now challenge was instituted at the outset of the SSI program. Such a contemporaneous interpretation and implementation of the statute by the agency charged with setting the program in motion is entitled to great deference.

Significantly, moreover, the regulations prescribing the listings approach were in effect in 1976 when Congress enacted the statutory directive that the Secretary publish "criteria" for evaluating disability in children. In fact, the

pairments. Those impairments which were determined to impact on the child's development to the same extent that the adult criteria have on an adult's ability to engage in substantial gainful activity were deemed to be of "comparable severity" to the adult listing.

Senate Report on the 1976 Act recognized, quoting the central regulatory provision, that "[t]he regulations which have been issued with regard to disability for children state that if a child's impairments are not those listed, eligibility may still be met if the impairments 'singly or in combination . . . are determined by the Social Security Administration, with appropriate consideration of the particular effect of the disease processes in childhood, to be medically the equivalent of a listed impairment.'" S. Rep. No. 1265, 94th Cong., 2d Sess. 24 (1976). Section 501(b) of the 1976 Act was enacted in response to concerns expressed by state agencies and Congress that SSA had not issued more specific or definitive guidelines to implement the general principle of medical equivalence embodied in the regulations quoted in the Senate Report. S. Rep. No. 1265, *supra*, at 24-25. The Senate Report recognized the difficulty of developing "objective criteria" for determining how to apply the disability definition to children; but the Committee perceived a need for uniform guidance, and it noted that "SSA ha[d] been circulating draft regulations with criteria for child disability for some time" (*id.* at 25). This legislative history manifests no disagreement with the basic regulatory requirement that a child's impairment must meet or equal a listed impairment, taking due account of the particular effect of the disease processes in children. To the contrary, the statutory directive plainly contemplated that the "criteria" to be issued by the Secretary would implement that requirement.

In response to Section 501(b) of the 1976 Act, the Secretary published proposed regulations in December 1976 (41 Fed. Reg. 53,042) and final regulations in March 1977 (42 Fed. Reg. 14,705). Those regulations retained the

general standards of disability for children that were contained in 20 C.F.R. 416.904 (1975), including the general standard of medical equivalence. 42 Fed. Reg. 14,707-14,708 (1977). But in order to furnish the more specific guidance mandated by Congress, the regulations added a new Part B to the Appendix of listed impairments, which contained "additional medical criteria" for the evaluation of children where the criteria in Part A do not give appropriate consideration to the "particular disease process in children." 42 Fed. Reg. 14,708 (1977). The Secretary made clear in the preamble to these regulations, however, that the special listings in Part B did not contain new substantive standards, but rather were intended to "clarify existing adjudicative guides" and "facilitate the decision making process" by furnishing specific criteria directly applicable to children. *Id.* at 14,705. As a result, the Secretary stressed, "[d]eterminations of disability of children have been made and will continue to be made under the authority provided in § 416.904 and in consideration of the basic requirements stated therein" (*ibid.*).

Thus, the basic requirement that an applicant for child's disability benefits establish that his impairment meets or equals a listed impairment was adopted by the Secretary at the very outset of the SSI program and was given more specific content in 1977 in the manner contemplated by Congress. There accordingly is no merit to respondents' contention that the Secretary's current regulations embodying the same approach (see 20 C.F.R. Pt. 404, Subpt. P, App. 1; 416.906, 416.924, 416.925) are inconsistent with congressional intent.

For the foregoing reasons and the additional reasons stated in the petition, it is respectfully submitted that the petition for a writ of certiorari should be granted.

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Acting Solicitor General

MAY 1989

No. 88-1377

(4)

Supreme Court of the United States
FILED
MAY 10 1989
JOSEPH F. SPANGL, JR.

In the Supreme Court of the United States

OCTOBER TERM, 1988

LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

JOINT APPENDIX

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PETITION FOR A WRIT OF CERTIORARI
FILED: FEBRUARY 15, 1989
CERTIORARI GRANTED: MAY 15, 1989

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* The opinion of the court of appeals, the order of the court of appeals denying rehearing, and the opinion of the district court are printed in the appendix to the petition for writ of certiorari and have not been reproduced here.

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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

No. 83-3314

ZEBLEY, BRIAN, BY HIS PARENT AND NATURAL GUARDIAN,
ZEBLEY, JOHN, ON BEHALF OF HIMSELF AND ON BEHALF OF A
CLASS ALL OTHER SIMILARLY SITUATED

INTERVENOR: RAUSHI, EVELYN, BY HER PARENT AND
NATURAL GUARDIAN, RAUSHI, MARY

INTERVENOR: (4) LOVE, JOSEPH, JR., BY HIS PARENT AND
NATURAL GUARDIAN, MARGARITE LOVE

v.

MARGARET HECKLER, SECRETARY OF HEALTH AND HUMAN
SERVICES

RELEVANT DOCKET ENTRIES

Date	NR	Proceedings
<i>1983</i>		
July 12	1	Complaint, filed.
July 12	1	Summons exit.
July 12	2	MOTION AND ORDER APPOINTING MICHAEL DONAHUE TO SERVE COMPLAINT AND SUMMONS ON DEFT., FILED. 7/12/83 copy with summons given to counsel.
July 14	3	Return of service of summons and complaint with affidavit of M. Kaufman re: served deft on 7-12-83, filed.
Sept. 2	4	MOTION TO INTERVENE, BRIEF

Date	NR	Proceedings
		IN SUPPORT, NOTICE, FILED. (Complaint of Intervenor attached).
Sept. 9	5	Answer, filed.
Sept. 9	5	Issue joined.
Oct. 6	6	Gov't response to request for admissions, filed.
Oct 13	6	PLFF-INTERVENOR JOSPEH LOVE, JR.'S MOTION FOR CLASS CERTIFICATION, MEMORANDUM OF LAW, CERTIFICATE OF SERVICE, FILED.
Oct. 18	8	STIPULATION & ORDER EXTENDING DEFTS TIME TO RESPOND TO PLFF'S MOTION TO INTERVENE TO 10-15-83, FILED. 10/18/83 entered & copies mailed. JF
Oct. 28	8	STIPULATION & ORDER EXTENDING DEFT'S TIME TO RESPOND TO PLFF'S MOTION FOR CLASS CERTIFICATION TO 11-25-83, FILED. 10/28/83 entered & copies mailed. JF
Nov. 1	10	EVELYN RAUSHI's MOTION TO INTERVENE, MEMORANDUM OF LAW, NOTICE, FILED. (COMPLAINT ATTACHED).
Dec. 14	11	Gov't opposition to motion for class certification, filed.
Dec. 20	12	STIPULATION & ORDER EXTENDING DEFT'S TIME TO RESPOND TO PLFF'S MOTION FOR CLASS ACTION CERTIFICA-

Date	NR	Proceedings
		TION TO 12-9-83, FILED. 12/20/83 entered & copies mailed. JF
Dec. 22	13	Plff's response to defts opposition to motion for class certification, filed.
1984		
Jan. 11	14	ORDER THAT PLFFS' MOTION FOR CLASS CERTIFICATION IS GRANTED & THIS ACTION MAY BE MAINTAINED AS A CLASS ACTION, ETC., FILED. 1/11/84 entered & copies mailed. JF
Mar. 26	15	GOVT'S MOTION FOR REMAND, MEMORANDUM OF LAW, NOTICE, CERTIFICATE OF SERVICE, FILED.
Apr. 6	16	Potential intervenor, Evelyn Raushi's memorandum in opposition to Govt's motion to remand, filed.
Apr. 26	17	Answer, filed.
Apr. 26	17	Issue joined.
June 18	18	JOINT MOTION TO AMEND THE ORDER SETTING 6-18-84 AS THE DATE FOR COMPLETION OF DISCOVERY & 6-18-84 AS THE DATE THE CASE WILL BE READY FOR TRIAL, BRIEF IN SUPPORT, CERTIFICATE OF SERVICE, FILED.
June 22	18	ORDER THAT MOTION TO AMEND THE ORDER OF 3-12-84 IS GRANTED. THE PARTIES SHALL HAVE UNTIL 9-18-84 TO COMPLETE DISCOVERY & THE

Date	NR	Proceedings
		MATTER SHALL BE LISTED FOR TRIAL ON 10-1-84, FILED. 6/22/84 entered & copies mailed. JF
June 28	18	PLFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT, BRIEF IN SUPPORT, CERTIFICATE OF SERVICE, FILED.
July 18	18	GOVT'S MOTION FOR SUMMARY JUDGMENT, BRIEF IN SUPPORT, CERTIFICATE OF SERVICE, FILED.
Sept. 27	20	PLFF'S MOTION FOR ORDER COMPELLING DISCOVERY OR FOR SANCTIONS, MEMORANDUM OF LAW, NOTICE, CERTIFICATE OF SERVICE, FILED.
Oct. 1	22	Withdrawal of appearance of Margaret L. Hutchinson, AUSA for Margaret Heckler & appearance of Joan K. Garner, AUSA for same, filed.
Oct. 12	23	MEMORANDUM & ORDER THAT DEFT'S MOTION FOR PARTIAL SUMMARY JUDGMENT IS DENIED; PLFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT IS GRANTED. THE CASE IS REMANDED TO THE SECRETARY FOR CALCULATION AND AWARD OF BENEFITS, FILED. JF 10/12/84 entered & copies mailed.

Date	NR	Proceedings
Oct 24	24	Govt's brief in opposition to motion for order compelling discovery or for sanction filed.
1985		
Mar. 11	25	DEFT'S MOTION FOR SUMMARY JUDGMENT, BRIEF, CERTIFICATE OF SERVICE, FILED.
Mar. 11	26	DEFT'S UNCONTESTED MOTION TO REMAND CLAIM OF EVELYN RAUSHI ONLY, PURSUANT TO NEW SOCIAL SECURITY LEGISLATION, CERTIFICATION OF UNCONTESTED MOTION, CERTIFICATE OF SERVICE, FILED.
Mar. 13	26	ORDER THAT CLAIM OF INTERVENOR EVELYN RAUSHI ONLY IS REMANDED TO SECY OF HHS, FILED. 3/14/85 entered & copies mailed.
Mar. 27	27	STIPULATION & ORDER THAT PLFFS HAS UNTIL 4/30/85 TO FILE RESPONSE TO DEFTS MOTION FOR SUMMARY JUDGMENT, FILED. 3/28/85 entered & copies mailed.
Apr. 30	28	Plffs Memorandum of Law in Opposition to Defts Motion for Summary Judgment, Certificate of Service, filed.

Date	NR	Proceedings
Apr. 30	29	Appendicies to Plffs Memorandum of Law, filed.
May 20	30	Defts Reply to Plffs Memorandum of Law in Opposition to Defts Motion for Summary Judgment, cert of serv, filed.
Sept. 18	31	ORDER DTD 12/21/83 THAT LEAVE TO INTERVENE AS PLFFS IS GRANTED, FILED. 9/18/85 entered & copies mailed.
Sept. 18	(4)	Complaint of Intervenor Joseph Love, Jr., filed.
<i>1986</i>		
Mar. 3	32	Deft's Amendment to Brief in Support of Motion for Summary Judgment, Certificate of Service, filed.
July 17	33	MEMORANDUM AND ORDER THAT DEFT'S MOTION FOR SUMMARY JUDGMENT IS GRANTED IN PART THE CLAIMS OF THE PLFF CLASS, CHALLENGING THE SECRETARY'S REGULATIONS REFERRED TO IN THE COMPLAINT ARE DISMISSED WITHOUT PREJUDICE TO THE CLAIMS OF THE NAMED PLFFS INTERVENOR PLFFS AND INDIVIDUAL CLASS MEMBERS, FILED. 7/17/86 entered and copies mailed.

Date	NR	Proceedings
Aug. 7	34	Plff's Notice of Appeal, filed. (86-1518) 8/7/86 copies to: D. Spitz, Clerk USCA, Judge Fullam, J. Garner, AUSA.
Aug. 7	35	Copy of Clerk's Notice to USCA.
Aug. 11	36	Copy of transcript purchase order form, filed.
Aug. 11	36	RECORD COMPLETE FOR PURPOSES OF APPEAL - TRANSCRIPT NOT NEEDED.
Aug. 11	37	Copy of TPO form, filed.
Sept. 10	38	PLFF'S MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS, STATEMENT IN SUPPORT THEREOF, FILED.
Oct. 1	39	Certified Copy of Order from U.S.C.A. dated 9/30/86 that the appeal is dismissed filed.
Oct. 10	(38)	ORDER THAT THE PLFFF BE PERMITTED TO PROCEED IN FORMA PAUPERIS WITHOUT PAYMENT OF THE COSTS OF SAID PROCEEDING OR SECURITY THEREFORE, FILED. 10/10/86 entered and copies mailed.
<i>1987</i>		
Mar. 26	40	PLFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT, BRIEF, CERT. OF SERVICE, FILED.
Apr. 7	41	DEFT'S UNAPPOSED MOTION FOR EXTENSION OF TIME TO

Date	NR	Proceedings
		FILE MOTION FOR SUMMARY JUDGMENT, CERT OF SERVICE, FILED.
Apr. 15	42	Stipulation to Remand to Sec. of Health and Human Service, filed.
Apr. 23	42	ORDER THAT THIS MATTER IS REMANDED TO THE SOC. OF HEALTH AND HUMAN SERVICES, ETC., FILED. 4/23/87 ENTERED AND COPIES MAILED.
Jun. 16	43	Plff's Notice of Appeal, filed. (88-3314) 6/16/87 copies to: Clerk, U.S.C.A., D. Spitz, Judge Fullam, Joan K. Garner, AUSA
Jun. 16	44	Copy of Clerk's Notice to U.S.C.A., filed.
July 22	44	RECORD COMPLETE FOR PURPOSES OF APPEAL.
Aug. 4	45	Certified copy of order dated 8/3/87 from U.S.C.A. that Appellee's letter-Motion to dismiss appeal for lack of jurisdiction is granted, etc., filed.
Sep. 3	46	PLFF'S MOTION FOR CERTIFICATION AND ENTRY OF JUDGMENT, MEMO., CERT. OF SERVICE, FILED.
Sep. 14	47	Deft's Response to Motion for Certification and Entry of Final Judgment, Cert. of Service, filed.
Sept. 16	48	Deft's Amended Certificate of Service, filed.

Date	NR	Proceedings
Sept. 25	49	Plff's Reply Memo in Support of Rule 54(b) Certification, Cert. of Service, filed.
Oct. 27	(46)	ORDER THAT THIS COURT HAS DIRECTED THE ENTRY OF FINAL JUDGMENT OF THE CLAIMS OF PLFF & THAT THERE IS NOT JUST REASON FOR DELAY, FILED. 10/29/87 entered & copies mailed
Nov 5	50	Plff's Notice of Appeal, filed (USCA 87-1692). 11/5/87 copies to: M. Kauffman, Esq. J. Garner, Esq., D. Spitz, Clerk, USCA, Judge Fullam
Nov 5	51	Copy of Clerk's Notice to USCA, filed.
Nov 10	52	Copy to TPO form, filed.
Nov 12	52	RECORD COMPLETE FOR PURPOSES OF APPEAL - TRANSCRIPT NOT NEEDED.
1988		
Aug 19	53	Deft's Praecipe to file copy of supplemental transcript, filed.
Oct 27	54	Certified copy of order from USCA that the judgment of this Court entered 4/23/87 as certified final by the order entered 10/29/87 is vacated, in part and the cause is remanded to this Court, etc., filed.
Nov 21	55	PLFF'S MOTION FOR SUMMARY JUDGMENT DIRECTED TO BE ENTERED BY THE THIRD CIRCUIT COURT OF APPEALS, MEMO., CERTIFICATE OF SERVICE, FILED.

Date	NR	Proceedings
Nov. 21	56	DEFT'S MOTION FOR STAY, MEMO., CERTIFICATE OF SERVICE, FILED.
Dec. 5	57	Plff's Memo in Opposition to the Secretary's Motion for a Stay of Proceedings, filed.
Dec. 6	58	Deft's Memo of Points & Authorities in Opposition to Plff's Motion for SUMMARY Judgment, filed.
Dec. 15	59	PLFF'S MOTION FOR REMAND AND PRETRIAL SUMMARY JUDGMENT, MEMO., CERTIFICATE OF SERVICE, FILED.
Dec. 22	60	Deft's reply to Plff's Memo in opposition to the Secretary's Motion for a Stay of Proceedings, Certificate of Service, filed.
Dec. 30	61	Plff's Reply to Deft's Memo of Points & Authorities in Opposition to Plff's Motion and Response to Deft's Memo in Opposition to the Secretary's Motion for a stay of Proceedings and for Summary Judgment, filed.
<i>1989</i>		
Jan. 6	62	Deft's response to Plff's Motion to remand, filed.
Jan. 19	63	Argued Sur: hearing of 1/12/89. Plff's motion for Summary Judgment and Government Motion for Stay, filed.
Jan. 26	64	Argued Sur: hearing of 1/26/89 re: proposed summary judgment Order, C.A.V., filed

Date	NR	Proceedings
Feb. 3	65	Deft's praecipe for filing declaration, filed.
Mar. 27	66	Govt's Information regarding pending legislation in Congress, filed.

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 88-1009

ZEBLEY, BRIAN, BY HIS PARENT AND NATURAL GUARDIAN,
ZEBLEY, JOHN, ON BEHALF OF HIMSELF AND ON BEHALF OF A
CLASS ALL OTHER SIMILARLY SITUATED

INTERVENOR: RAUSHI, EVELYN, BY HER PARENT AND
NATURAL GUARDIAN, RAUSHI, MARY

INTERVENOR: LOVE, JOSEPH, JR., BY HIS PARENT AND
NATURAL GUARDIAN, MARGARITE LOVE

APPELLANTS

v.

OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND
HUMAN SERVICES

RELEVANT DOCKET ENTRIES

Record, Exhibits & Brief Information/Filing:

11/18/87	Briefing Notice Issued
1/14/88	Brief for <i>Amicus</i> American Academy of Child and Adolescent Psychiatry
1/14/88	Brief for <i>Amicus</i> Pennsylvania Protection and Advocacy, Inc., et al.
1/14/88	Appendix
1/15/88	Brief for <i>Amicus</i> Spina Bifida Associa- tion of Greater Los Angeles
1/15/88	Brief for Appellants

Record, Exhibits & Brief Information/Filing:

1/25/88	Extension of time to file Appellee's Brief—Order Filed: 1/27/88—Exten- sion to: 2/26/88
2/26/88	Brief for Appellee
3/15/88	Reply Brief for Appellants

Summary of Events

ARGUED:	5/3/88
PANEL:	Gibbons, ChJ, Mansmann & Cowen, CJ—
OPINION:	8/10/88—Signed
JUDGMENT:	Vacating in part, affirming in pari (bj)
PET. FOR REHG.:	10/3/88 by Appellee. See 10/3/88 Order P2 Denied In Banc—10/18/88 Judges Seitz & Hutchinson would have granted Rehear- ing In Banc. (bj)
MANDATE ISSUED:	10/26/88
RECORD RETURNED:	10/26/88
CERTIORARI FILED:	2/15/88—S.C. #88-1377

Date	Filings—Proceedings
1987	
Dec. 14	Motion by aplt. for modification of brief- ing schedule, filed. (gt)
Dec. 14	Order (Clerk) denying above motion as presented. Apls. to f&s brief & joint appendix on or before 1-14-88. Aplee. may make its own motion for X if necessary, filed. (gt)

Date	Filings — Proceedings
1988	
Jan. 15	Motion by aplt. for leave to file B in excess of 50 pages, filed. (gt)
Jan. 20	Motion by Spina Bifida Assoc., etc. for leave to file brief of Amici Curiae, filed. (gt)
Jan. 21	Order (Clerk) granting motion to exceed page limit with filing as of date of this order, filed. (gt)
Jan. 28	Order (<i>Sloviter</i> , C.J.) granting above mot to file brief amici curiae by Spina Bifida Assoc. of Greater L.A., in light of the representation made that cnsl for apees has no objection to filing of a brief amici curiae, filed. (adl)
Mar. 7	Letter dd. 2-26-88 from Peter Krynski, Esq., cnsl for appee, rec'd for the info of the Ct.
Mar. 15	Motion of aplt's for leave to file RB one day OT & for additional pagination filed. (gt) SEND TO MERITS PANEL
Mar. 18	Order (Clerk) referring above motion to merits panel, filed. (gt) SEND TO MERITS PANEL
Mar. 25	Let. ddt. 3-21-88 from aplee. sent pur. Rule 28(j) of F.R.A.P., filed. (gt)
Mar. 22	Order (<i>Gibbons</i> , Mansmann and Cowen) granting aplt's. mot. to file R.B. one day OT and for add'l. pagination, filed. (gt)
Apr. 7	Letter dd 4/6/88 pur. 28(j), F.R.A.P., rec'd. from Jonathan M. Stein, Esq., cnsl for appellants, rec'd for info of Ct. (gt) SEND TO MERITS PANEL

Date	Filings — Proceedings
May 23	Let. ddt. 5-12-88 from Peter J. Krynski, Esq., sent pursuant to Rule 28(j) F.R.A.P., filed. (gt)
June 1	Letter dd. 5/31/88 from Jonathan M. Stein, Esq., cnsl for aplt's, pur. to Rule 28(j), F.R.A.P., filed. (gb)
June 6	Let. from aplee. ddt. 6-1-88, sent pursuant to Rule 28(j), filed. (gt)
Aug. 16	Motion for Enlargement of Time to Seek Rehearing & Rehearing in Banc, by Aplee, O. Bowen, to & Incl. Sept. 23, 1988, w/serv., fld. (bj)
Aug. 17	ORDER (Clerk) granting above motion to & incl Sept. 23, 1988, fld. (bj)
Aug. 19	Ltr dtd 8-17-88 frm M.A. Kaufman, Esq., rec'd (bj)
Sept. 27	Motion For Leave To File Petition For Rehng & Suggestion For Rehng in Banc with Two Additional Opinions Attached as Part of Exhibit Required by Local Rule 22.1, by the Appellee, w/serv., fld. (bj)
Oct. 3	Order (Mansmann, C.J.) granting the above motion, fld. (bj)
1989	
Jan. 12	Ltr dtd 1-9-89 frm Clk of U.S. Supreme Ct. advising this Ct. that on 1-9-89 and Order was filed extending the time to & including Feb. 15, 1989 w/in which to file a pet. for writ of Cert., rec'd (bj)

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

BRIAN ZEBLEY, BY HIS PARENT AND NATURAL GUARDIAN,
JOHN ZEBLEY 106 WASHBURN STREET, UPLAND,
PENNSYLVANIA ON BEHALF OF HIMSELF AND ON BEHALF OF A
CLASS ALL OTHER SIMILARLY SITUATED, PLAINTIFFS

v.

MARGARET HECKLER, SECRETARY OF HEALTH AND HUMAN
SERVICES, DEFENDANTS

CLASS ACTION

COMPLAINT

I. PRELIMINARY STATEMENT

1. This class action arises under provisions of Social Security Act creating Supplemental Security Income disability benefits for poor disabled and blind children, 42 U.S.C. § 1383(c)(3), and is being brought to insure that children's disabilities are adjudged by the Secretary under a comparable scheme to that of adults in conformity with the Act.

2. The gravamen of plaintiffs' claim is that the Secretary of Health and Human Services ["Secretary"] has promulgated regulations and issued instructions to personnel of the regional, district, disability determination divisions, Office of Hearings and Appeals of the Social Security Administration (SSA) whereby children have their entitlement to SSI disability benefits based solely on the grounds that they have a listed impairment or the medical equivalent of a listed impairment 20 C.F.R. § 416.923, in

contravention of the Act's requirement that a child be considered disabled "if he suffers from any medically determinable physical or mental impairment of comparable severity" to that which disables an adult under the program. 42 U.S.C. § 1382(c)(a)(3)(A). The issue, therefore, is the statutory construction of the phrase "comparable severity". The Secretary has established three routes by which an adult may prove disability, known as (1) "listed impairments"; (2) "medical equivalence" and "medical and vocational factors". 20 C.F.R. § 416.901-416.920. The first two categories are narrow and consist solely of medical findings promoting administrative convenience and efficiency by avoiding a need for further evaluation of claimants who meets those criteria. The third route is broader and more flexible and requires consideration of the claimants actual ability to function or perform substantial gainful work. The Secretary has required children, however, to prove disability only by one of the first two routes. Congress intended a single standard for SSI disability and the Secretary has violated that congressional authorization.

Injunctive and declaratory relief is therefore sought to ensure that fundamental principle of constitutional and statutory law and otherwise proper legal standards are used in the determination of disability for children.

II. JURISDICTION

3. Jurisdiction is conferred on this Court by 42 U.S.C. § 405(g) and 42 U.S.C. § 1383(c)(3) which grant jurisdiction to the federal courts to review a final decision of the Secretary with regard to a claim for benefits under the SSI program as plaintiffs have fully presented their claims for benefits to the Secretary and have received a "final decision" of the Secretary within the meaning of the Social

Security Act. These jurisdictional statutes, pursuant to the U.S. Supreme Court interpretation, also provide for appeals which are class actions in the district court.

4. Jurisdiction is also conferred upon federal defendants by 28 U.S.C. § 1361 to compel an officer of the United States to perform his duty.

III. PARTIES

5. Plaintiff, Brian Zebley, by his father and natural guardian, John Zebley, is a resident of Pennsylvania and the County of Delaware claiming benefits under Social Security No. 201-58-0223. Based on an application filed September 12, 1980 Brian M. Zebley was granted Supplemental Security Income benefits pursuant to a finding that he was under a disability as defined in the Social Security Act.

6. Defendant, Margaret Heckler, Secretary of the United States Department of Health and Human Services is statutorily responsible for the administration of the Social Security Administration and payment of disability benefits for disabled children under the Supplemental Security Income Disability Program, 42 U.S.C. § 1381 et seq.

IV. CLASS ACTION ALLEGATIONS

7. The named plaintiff brings this action on his own behalf and pursuant to Rule 23 (a)(b), Federal Rules of Civil Procedure on behalf of all other persons similarly situated. The class is composed of Social Security Income Disability child beneficiaries who have been or are receiving disability benefits or who, but for the unlawful policy of the secretary would be receiving benefits and whose entitlement have been or are now threatened with reduction or cessation because the Secretary determines child dis-

ability under a different scheme than adults in violation of 42 U.S.C. § 1383(c)(a)(3)(A).

8. This class is so numerous that joinder of all persons is impossible and impracticable. It is not possible to determine the precise numbers of individuals affected by the Secretary's policy because the Social Security Administration does not maintain statistics regarding the reasons for cases being denied beyond initial denial level. With respect to initial determination of children's SSI disability claims, in 1978 nationally there were 23,253 denial decisions based on a failure to meet the medical standards specifically applicable to children. In 1979 this national figure was 28,812 and for the first two months of 1980 there were 7,385 such denials.

9. In 1983 as of the first six months of 1983 nationally there were 10,000 such denials. These figures are for all children due SSI blind/disabled benefits at the initial level and do not include termination decisions.

10. There are questions of law and fact common to the entire class which predominate over questions regarding only the named plaintiff. These include, inter alia:

(a) Whether the defendants violate the Social Security Act by violating the "comparable severity" provision of 42 U.S.C. § 1382c(a)(3)(A) by failing to consider factors for children which are comparable to vocational factors for adults in clear contravention of the plain language of the statute and the congressional intent in enacting the program.

(b) Whether the defendant violate the due process clause of the 5th Amendment of the United States Constitution by arbitrarily and capriciously and without authority establishing a separate and more restrictive standard for evaluating a child claimant disability than an adult claimant's disability.

11. The above claims of the named plaintiffs are typical of the claims of the class they represent.

12. Named plaintiffs will fairly and adequately represent and protect the interest of the class they represent. They have the same interest in having applied to them the same legal standards as sought for all child disability claimants. Plaintiff's attorneys have successfully litigated similar class actions and possess the experience and expertise to handle class actions of this type.

13. The defendants have denied or will soon deny plaintiffs and the proposed class their Social Security Act entitlements and due process of law based on policies and regulations of general application of the class.

V. FACTUAL ALLEGATIONS OF NAMED PLAINTIFF

14. Brian Zebley, born July 13, 1978 was from September 12, 1980 to January 26, 1983 a recipient of Supplemental Security Income Disability benefits as a disabled child.

15. Subsequent to the initial determination of disability the S.S.A. determined that the child disability ceased in May, 1982 and that his eligibility for Supplemental Security Income terminated July 31, 1982.

16. Said determination was duly appealed to all levels of administrative review and on May 20, 1983 the Appeals Council entered the final decision of the Secretary finding that Brian Zebley's disability had ceased, copy attached Appendix "A". The decision of the Appeals Council incorporated by reference the decision of the Administrative Law Judge on January 26, 1983, copy attached as Appendix "B".

17. Brian Zebley was born with brain damage manifested by spastic right hemiparesis and mental retar-

dation. He suffers from developmental delay, eye problems and muscle skeletal impairments on the right side.

18. Brian Zebley walks with a limp, has trouble falling down and cannot go downstairs without help. He has problems with dexterity in his right arm. He slurs his words, has problems with drooling, and although four years old is not yet toilet trained.

19. On a mental development scale, Brian Zebley functions at less than two years of age.

20. It was nonetheless the decision of the Secretary that Brian Zebley was not disabled within the meaning of the Act since he did not meet or equal a listed impairment. No consideration was given to Brian's functioning, nor to any factor comparable to medical and vocational factors considered for adults.

VI. SUPPLEMENTAL SECURITY INCOME DISABILITY PROGRAM

21. In order to be eligible for Supplemental Security Income 42 U.S.C. § 1383, *et seq.* an individual must meet a test for disability, blindness or old age, and meet certain income and resource tests of need under 42 U.S.C. § 1382.

22. 42 U.S.C. § 1382(c)(a)(3)(A) provides that a child will be considered disabled "if he suffers from any medically determinable physical or mental impairment of comparable severity" to that which disables an adult under the program.

23. The Secretary has established three routes by which an adult may prove disability, known as (a) "listed impairments"; (b) "medical equivalence", (c) "medical and vocational factors" 20 C.F.R. § 416.901-920.

24. The Secretary has provided a child under age 18 will be considered disabled if he is "suffering from any medically determinable physical or mental impairment

which compares in severity to an impairment that would make an adult disabled "20 C.F.R. § 416.906, but provides that the determination of comparability is limited to an impairment which meets the duration requirement and (1) is listed in Appendix 1 of subpart P of part 404 of this chapter; or (2) is determined by us to be medically equal to an impairment listed in Appendix 1 of subpart B of part 404 of this chapter." 20 C.F.R. § 416.923.

25. Accordingly for children who claim disability no consideration is given to the functional equivalent or comparable factors available to an adult under 20 C.F.R. § 416.920(e), (f), 416.921, 416.922, 416.945, 416.971-975.

26. Thus a child receives no consideration for the age comparable individualized consideration of pertinent facts such as capacity to undertake basic activities, learning, growth, development, academic attainment, school performance and capacities and functional limitations imposed by physical or mental impairments.

27. Plaintiff has accordingly exhausted his administrative remedies within the meaning of the statute and decisions of this court.

28. Plaintiff and members of plaintiffs class have been terminated, or threatened with termination of benefits, or have been denied benefits without authority.

29. The above constitutes fixed and final policies and practices of the defendants affecting the plaintiffs class as a whole.

30. Federal defendants have acknowledged that most SSI beneficiaries rely upon their disability payments to provide the necessities of life.

31. Plaintiffs will suffer immediate and irreparable harm, including loss of these necessities of life, emotional language and distress, and loss of life if preliminary and permanent conjunctive relief is not granted.

VII. CLAIMS OF PLAINTIFFS CLASS AND NAMED PLAINTIFFS

FIRST CLAIM

32. Defendants as a matter of fixed policy and regulations refuse to consider "all pertinent facts" and medical and vocational factors in determination of disability for children in violation of a Social Security Act, 42 U.S.C. § 1382(a)(3)(A).

SECOND CLAIM

33. Defendants as a matter of fixed policy arbitrarily and capriciously and without authority violate due process and equal protection guarantees of fundamental fairness embodied in the 5th Amendment requiring child disability applicants and recipients to meet a more stringent standard than that applied to adults.

THIRD CLAIM (BRIAN ZEBLEY)

34. The final decision of the Secretary with regard to Brian Zebley should be reversed and/or remanded for reasons including but not limited to the following: (a) The decision is not supported by substantial evidence; (b) The decision fails to give appropriate weight to treating physicians' opinions and evidence; (c) The decision unlawfully relies on, in derogation of the substantial evidence in the file, the opinion of non-treating physicians who have not examined claimant.

(c) The position taken by the Secretary is otherwise not substantially justified, supported by substantial evidence or in conformity with the law.

WHEREFORE, Plaintiff prays this Honorable Court:

(1) That this Court take jurisdiction of the action and declare this a class action pursuant to 23(a), (b1) and (b2), Federal Rules of Civil Procedure;

(2) That this Court, pursuant to 28 U.S.C. § 2201 and 2202 and Rule 57, Federal Rules of Civil Procedure, declare that the defendants are erroneously and illegally threatening to terminate, terminating, or denying plaintiffs and their class members SSI benefits by requiring they meet a standard which is separate and more restrictive for child claimants than adults in violation of 42 U.S.C. § 1382(c)(3)(A).

(3) That this Court, pursuant to Rule 65, Federal Rules of Civil Procedures, grant preliminary and permanent injunctive relief, enjoining defendants from terminating or threatening to terminate, denying or threatening to deny SSI child claimants, named plaintiff, and their class members based on a requirement that children meet a separate and more restrictive standard for disability than that applicable to an adult;

(4) Enter judgment in favor of named plaintiff and against defendant reversing defendants decision that plaintiff is not disabled in that plaintiff does meet or equal even the restrictive standard unlawfully employed by defendants, and ordering defendant to pay benefits in accordance with title XVI of the Social Security Act, or in the alternative, vacate the administrative decision appealed from, remanding this matter to the Social Security Administration for further proceedings which will comport with the requirements of the act;

[sic] (4) That this court grant plaintiffs counsel fees and costs for pursuing this action under the Equal Access to Justice Act, 28 U.S.C. A. § 2412 (Supplement 1981), and the Civil Rights Attorneys fees awards act of 1976, 42 U.S.C. A. § 1988.

(5) That such other relief be granted as found just and proper.

/s/ M. Kaufman

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

BRIAN ZEBLEY, ET AL.

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES

[Filed Jan. 11, 1984]

ORDER

AND NOW, this 10th day of January, 1984, upon consideration of plaintiffs' motion for class certification and defendant's opposition thereto, it is ORDERED:

1. Plaintiff's motion is GRANTED, to the extent set forth below.¹

¹ Class-action treatment is appropriate to address the validity and interpretation of the regulations establishing the standards for determining child disability entitlements. To adopt the defendant's arguments would virtually repeal Federal Rule 23. On the other hand, I reject plaintiff's proposed class definition, since it presupposes the correctness of plaintiff's legal argument on the merits; to adopt plaintiffs' definition of the class would mean that, if plaintiffs lose, the class would have been decertified.

2. This action may be maintained as a class action pursuant to F.R.C.P. 23(b)(2), on behalf of a class defined as follows:

"All persons who are now, or who in the future will be, entitled to an administrative determination (whether initially, on reconsideration, or on reopening) as to whether supplemental security income benefits are payable on account of a child who is disabled, or as to whether such benefits have been improperly denied, or improperly terminated, or should be resumed."

/s/ John P. Fullam

J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

BRIAN ZEBLEY, 201-58-0223

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES

[Filed Oct. 12, 1984]

MEMORANDUM AND ORDER

FULLAM, J.

Since his birth on July 13, 1978, Brian Zebley has been afflicted with spastic right hemiparesis¹ and mental retardation. He was granted supplemental security income benefits based on his application of September 12, 1980. Subsequently, however, the Social Security Administration determined that his disability ceased as of May 1982, and that his eligibility for benefits terminated on July 31, 1982. Plaintiff, through his father, requested a post-termination hearing before an Administrative Law Judge (ALJ) but waived his right to appear.

¹ Hemiparesis is a weakness affecting the muscles on one side of the body. Schmidt's Attorney's Dictionary of Medicine at H-36 (1981).

On January 15, 1983, the ALJ issued his decision, in which he concluded that plaintiff was no longer disabled. Because the Appeals Council denied review, the ALJ's report stands as the final decision of the Secretary. That decision, however, is not supported by substantial evidence. Accordingly, plaintiff's motion for partial summary judgment must be granted and the matter remanded to the Secretary for calculation and award of benefits.²

In a termination proceeding such as this, a claimant must first introduce evidence that the underlying condition persists. Thereafter, he or she is entitled to a presumption of continuing disability. The burden then shifts to the Secretary, who must demonstrate an improvement in the claimant's condition such that the claimant is no longer disabled. *Kuzmin v. Schweiker*, 714 F.2d 1233, 1237 (3d Cir. 1983). Ordinarily, determining whether such improvement has occurred is a relatively straightforward matter of comparing the claimant's former condition with his or her current condition and determining whether the claimant can now undertake gainful activity.

Here, however, the claimant is a child suffering from developmental impairments, but whose capabilities have admittedly increased as he has gotten older. Thus, in one limited sense of the word, his condition has improved. Nonetheless, the medical evidence demonstrates that, adjusting for age, Brian is no better off now than he was when benefits were initially awarded in 1980. Consequently, it cannot be said that there is substantial evidence of improvement.

² On January 11, 1984, this court granted plaintiff's motion for certification of a class action challenging the validity of the Secretary's regulations governing the award of disability benefits to minors. In this motion for partial summary judgment, plaintiff assumes *arguendo* that the existing regulations are valid but contends that his termination was not proper under those regulations.

Benefits were initially awarded on October 24, 1980. Although the record before this court does not explicitly state what information was before the original disability examiner in 1980, several of the reports in this record are addressed to her and presumably formed the basis for her decision. Chief among these is a report dated October 22, 1980, from Dr. Mark Cohen, Brian's treating neurologist. Dr. Cohen concluded that Brian's "personal social and fine motor-adaptive skills are at approximately the 15 month level and his gross motor and language skills are at approximately the 12 month level." R.61. Thus, Brian's skills were at approximately 55% and 45% of the norm for his age of 27 months.

In determining that Brian was no longer disabled as of May 1982, the second disability examiner (and later the ALJ) relied upon reports by several treating physician and psychologists. One group of reports concerned surgery that Brian underwent to his right leg on February 24, 1982, namely, when his right Achilles tendon was lengthened. Thereafter, the supervising orthopedic surgeon noted that the operation was very successful in correcting Brian's gait. R.84.

Also considered by the second disability examiner was a report by Erika Surkin, M.Ed., a certified school psychologist, and Sharon Elvey, a resident in pediatrics. Ms. Surkin is a staff member at the Delco Elwyn Institute Development Center, where Brian has participated in various developmental therapy programs. She performed a psychological evaluation of Brian on July 2, 1981, when he was 11 days shy of his third birthday. She administered the Griffiths Mental Development Scales test, on which Brian achieved an overall mental age of 24.4 months, and a general intelligence quotient of 68. R.64-68. The report of Dr. Elvey is much less specific, but states that Brian is significantly delayed in his development. R. 76, R.86.

On September 20, 1982, the ALJ who was reviewing Brian's termination submitted the record to Dr. Gunter Haase, a board-certified neurologist and psychiatrist and professor of neurology at Pennsylvania Hospital. The ALJ requested that Dr. Haase review the record and respond to interrogatories. Dr. Haase replied on October 14, 1982, agreeing with the diagnosis of mental retardation and right hemiparesis. He concluded, however, that "The level of severity of these impairments is relatively mild," and that they did not rise to the level of a disability.

Of particular significance to this court's review of the ALJ's decision is a second report from Ms. Surkin, dated July 21, 1982. On that occasion, when Brian was just over 48 months old, he achieved the following scores on the Development Programming Test:

Perceptual/fine motor:	24 to 27 months
Cognition:	36 to 42 months
Language:	36 to 42 months
Social/emotional:	36 to 42 months
Self help:	20 to 23 months
Gross motor:	16 to 19 months

Ms. Surkin further commented that Brian had difficulty with motor coordination. His gross motor skills were limited by spasticity and incoordination. His balance was often poor when walking and climbing. One side was significantly weaker than the other. His motor problems are apparent with fine motor tasks. He had difficulty with items requiring fine coordination and depth perception. Brian held his head to the right and appeared to be using his right eye predominantly. He often misjudged distances.

R.103. A physical therapist at the Delco Center reported on July 15, 1982 that Brian's balance was poor and that he

fell frequently, though the operation on his heel had improved his foot and knee alignment. R.104. The ALJ submitted those additional reports to Dr. Haase and asked whether they warranted a change in Dr. Haase's evaluation. Dr. Haase responded as follows:

The additional material submitted includes a report, dated July 2, 1981, according to which Brian Zebly's intelligence quotient is 68. In another report dated July 21, 1982, I do not see a specific reference to the intelligence quotient but it would appear that the results at this time are consistent with those obtained one year previously.

In those sections of the Social Security Regulations specifically pertaining to children, under paragraph 112.05, the description reads "I.Q. of 60 - to 69, inclusive and the physical or other mental-impairment imposing additional and significant restriction of function or developmental progression.["] In this particular case, the accent would have to rest on the statement 'a physical or other mental impairment. . .'. There is evidence in the records that in Brian Zebly there is existing such a physical impairment because of spasticity which also has produced 'trouble walking' because of his poor balance. Nevertheless, he is described as riding his tricycle, playing ball, being able to walk upstairs, but requiring help walking down. It is also said, 'Brian enjoys fine motor activities. He is able to place shapes in a shape sorter and complete simple form boards and puzzles.'

It further is said that he 'feeds himself finger foods and uses a spoon, a fork with some help, and a cup. He is able to remove his coat and shirt independently.'

In my view, this would indicate that he has impairments in fine motor functions but the records would indicate that this does not represent a "additional and significant restriction of function or developmental progression."

As I understand the Social Security Regulations, the impairments of Brian Zebly would not meet these specific requirements.

R.106-07.

In reaching his decision, the ALJ relied heavily upon Dr. Haase's assessment. That reliance presents problems for two reasons. First, the Third Circuit has recently cautioned that expert medical opinions based on a paper record have "less probative force" than those based on a direct examination of a claimant. *Wier v. Heckler*, 734 F.2d 955, 963 (3d Cir. 1984). Second, and more seriously, Dr. Haase does not appear to have taken into account results of the gross motor and self-help skills tests. As noted above, Brian's skills in these areas were found to be at the 16-19 months, and 20-23 months, respectively. Given that Brian was 48 months old at the time those tests were administered, a conclusion that his development progression was not significantly restricted seems hardly supportable. Yet Dr. Haase drew that conclusion and the ALJ accepted it.

In addition, the ALJ mischaracterized the July 5, 1982 report of Brian's physical therapist. The ALJ stated that that report "implies that Brian's past problems with poor balance and frequent falling might be substantially eliminated by a properly fitted brace and the heel surgery." R.13. Although the therapist did state that Brian had outgrown his short leg brace and recommended that he get a new one, the heel surgery had been performed five months before the therapist's evaluation. Nonetheless, the

therapist noted that Brian's balance was still poor and he still fell frequently. Nowhere does the therapist's report imply that a new brace would correct the remaining problems. R.104.

In sum, there is no substantial evidence supporting the ALJ's conclusion that Brian's disability had ceased because he no longer suffered from a "significant restriction of . . . developmental progression." Instead, all of the first-hand recent medical evidence is to the contrary. Given that Brian has an I.Q. of 68, he therefore continues to meet the criteria of 112.05C, and should not have had his benefits terminated. This matter will accordingly be remanded to the Secretary for calculation and award of benefits.

This ruling does not, of course, preclude the Secretary from subsequently determining that Brian's condition has improved to such a degree that his benefits should be terminated, if there is evidentiary support for that conclusion.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

BRIAN ZEBLY

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES

ORDER

AND NOW, this 9th day of October, 1984, it is ORDERED that:

1. Defendant's Motion for Partial Summary Judgment is DENIED.
2. Plaintiff's Motion for Partial Summary Judgment is GRANTED. The case is remanded to the Secretary for calculation and award of benefits.

/s/ John P. Fulam

J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

IN THE MATTER OF EVELYN RAUSHI,
POTENTIAL INTERVENOR,

BRIAN ZEBLEY, BY HIS PARENT AND NATURAL GUARDIAN,
JOHN ZEBLEY, PLAINTIFF

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES, DEFENDANT

[Filed Mar. 13, 1985]

ORDER

AND NOW, this 13th day of March, 1985, upon consideration of the Secretary's uncontested motion, it is hereby

ORDERED

that the claim of intervenor Evelyn Raushi *only* is remanded to the Secretary of Health and Human Services pursuant to section 2 of the Social Security Disability Benefits Reform Act of 1984 for review in accordance with the provisions of the Social Security Disability Act as amended by section 2 of Pub. L. 98-460.

Evelyn Raushi's Social Security Number is 171-60-9163.

BY THE COURT:
/s/ John P. Fullam

J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 83-3314

IN THE MATTER OF JOSEPH LOVE JR., PLAINTIFF

BRIAN ZEBLEY, PLAINTIFF

v.

MARGARET HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES, DEFENDANT

[Filed Apr. 23, 1987]

ORDER

It is hereby ORDERED and DECREED, that the claim of Joseph Love Jr., by his mother Marguerite Love, for Supplemental Security Income benefits be REMANDED to the Secretary of Health and Human Services for a determination of eligibility for benefits in accordance with the Social Security Disability Benefits Reform Act of 1984.

BY THE COURT:
/s/ John P. Fullam

J.

**DEPARTMENT OF HEALTH &
HUMAN SERVICES**

Social Security Administration

Refer to:
SGC
201-58-0223

May 20, 1983

Office of Hearings and Appeals
PO Box 2518
Washington DC 20013

ACTION OF APPEALS COUNCIL ON REQUEST FOR REVIEW

Mr. John Zebley
for Brian Zebley
106 Washburn Street
Upland, PA 19015

Dear Mr. Zebley:

The request for review of the hearing decision in your case has been considered.

Section 416.1470 of Social Security Administration Regulations No. 16 (20 CFR 416.1470) provides that the Appeals Council will grant a request for review of a hearing decision where: (1) there appears to be an abuse of discretion by the administrative law judge; (2) there is an error of law; (3) the administrative law judge's action, findings, or conclusions are not supported by substantial evidence, or (4) there is a broad policy or procedural issue which may affect the general public interest. This section also provides that where new and material evidence is submitted with the request for review, the entire record will be evaluated and review will be granted where the Appeals Council finds that the administrative law judge's action, findings, or conclusion is contrary to the weight of the evidence currently of record.

The Appeals Council has concluded that there is no basis under the above regulations for granting the request for review. Accordingly, your request is denied and the hearing decision stands as the final decision of the Secretary in your case.

If you desire a court review of the hearing decision, you may commence a civil action in the district court of the United States in the judicial district in which you reside within sixty (60) days from the date of receipt of this letter. It will be presumed that this letter is received within five (5) days after the date shown above unless a reasonable showing is otherwise made. See section 1631(c)(3) of the Social Security Act, as amended (42 U.S.C. 1383(c)(3)) and section 422.210 of Social Security Administration Regulations No. 22 (20 CFR 422.210).

If a civil action is commenced, your complaint should name the Secretary of Health and Human Services as the defendant and should include the Social Security number(s) shown at top of this notice.

Sincerely yours,

/s/ VERRELL L. DETHLOFF, JR.
Verrell L. Dethloff, Jr.
Member, Appeals Council

cc:

Mr. Timothy W. Hunter
Chester, PA 19013

HO, Philadelphia, PA (ALJ Ennis, Jr.)

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

DECISION

IN THE CASE OF

JOHN ZEBLEY FOR BRIAN
(Claimant)

Claim for
Continuance of Disabled Child's
Supplemental Security Income

201-58-0223

(Wage Earner) (Leave Blank if same as above)

(Social Security Number)

This case is before the Administrative Law Judge on a request for hearing. A hearing was scheduled but not held, and the child's father waived his right to appear and testify, although fully informed of his right to do so, requesting instead that the decision be based on the written record alone. Claimant is represented by Timothy Hunter, a legal intern.

ISSUES

The general issue before the Administrative Law Judge is whether the claimant continues to be eligible for supplemental security income under Section 1614 of the Social Security Act. The specific issues are whether the claimant continues to be under a "disability" as defined in the Act and, if not, when such "disability" ceased.

LAW AND REGULATIONS

Section 1614(a)(3)(A) of the Social Security Act provides that a child under the age of 18 shall be considered to be disabled if he has any medically determinable physical or mental impairment which can be expected to result in

death or which has lasted or can be expected to last for a continuous period of not less than twelve months of comparable severity to that which would render an individual unable to engage in substantial gainful activity.

EVALUATION OF THE EVIDENCE

Based on an application filed September 12, 1980, Brian M. Zebley was granted Supplemental Security Income Benefits, payable to his natural father, John H. Zebley, pursuant to a finding that he was under a disability as defined in the Social Security Act. Subsequently, the Administration determined that the child's disability ceased in May, 1982 and that his eligibility for supplemental security income terminated July 31, 1982. Although development which ultimately led to that determination was begun as early as March, 1982 (see Exhibit 7), the parties were first informed of the determination by letter dated June 2, 1982 (Exhibit 4), the earliest communication which comports with the Secretary's program regarding due process notice in disability cessation cases. A timely request for hearing then was filed June 15, 1982.

The record indicates that claimant was born July 13, 1978 and presently is 4 years, 6 months old. Since about age one, the child has been attending stimulation and enrichment schooling in conjunction with the Delco Elwyn Institute.

Brian was born with brain damage manifested by spastic right hemiparesis and mental retardation (Exhibit 10). When evaluated in June, 1979 in connection with the Delco Elwyn Institute Infant Stimulation Program, the child had significant limitations in gross motor, strength, and language areas, although vision and fine motor control appeared to be satisfactory (Exhibit 8); overall, his

evaluators felt him to be functioning at about one-half of his chronological age (Exhibit 12).

Dr. Baker, one of the child's treating physicians, reported that he sat at 12 months, crawled at 15 months, and was speaking two-word [sic] combinations at 21 months, and overall appeared to be developing better than was expected considering the limitations apparent at birth (Exhibit 9). Similarly, when Dr. Cohen evaluated the child in October, 1980 for the Administration, he measured height, weight, and head circumference to be in the 25th to 50th percentile, and noted that his personal, social, and fine motor adaptive skills appeared commensurate with his chronological age; gross motor and language skills continued to lag, however (Exhibit 13).

Brian was re-evaluated July 2, 1981 by Erika Surkin, a Certified School Psychologist for the Delco Elwyn Institute (Exhibit 15). At the time, the child was 35 months old. His mental age was tested at 24 months, and subtests concerning social skills, eye-hand coordination, and performance ranged from 21 to 26 months. A companion Preschool Attainment Record test, based on assessments by his parents and on observations of the child was scored at 26 months. Qualitatively, Brian had good fine motor control; was friendly, sociable, and cooperative; was "quite verbal;" and was able to walk and climb stairs but, due to problems with his right leg and foot, often bumped into obstacles and had difficulty descending stairs.

Dr. Vanace, claimant's treating neurologist, found that his right leg and right arm both were about one-quarter short compared with their opposite members on the left, and that the child had some right hip subluxation. He prescribed the fitting of a right leg brace and an orthosis in the right shoe (Exhibit 16). On February 24, 1982 Brian's

right Achilles tendon was lengthened in a procedure at Einstein Medical Center by Dr. Guttman (Exhibit 17). As of May, 1982, Dr. Guttman assessed the procedure as having been successful; both the child and his parents were pleased with the results, he was normal weight-bearing, abnormalities of gait were substantially resolved, and the child had more endurance for walking. Dr. Guttman felt that no further surgery was required (Exhibit 21).

A full re-evaluation of the child was completed in July, 1982 by Ms. Surkin; Brian's teacher, Eileen Flynn joined in the psychological evaluation, and Peggy Daniel, a physical therapist, evaluated his physical capabilities (Exhibit 28). Brian was 48 months old in July, 1982. Psychologically, the following findings as to the child's skills were made: perceptual/fine motor, 24 to 27 months; cognition, 36 to 42 months; language, 36 to 42 months; social/emotional, 36 to 42 months; self/help, 20 to 23 months; gross motor, 16 to 19 months. Specifically, Brian was able to scribble, align toys, and unscrew a jar lid; group pictures and identify shapes and objects; follow simple commands and use simple sentences spontaneously; play simple games with other children and help with household tasks; wash and dry hands independently, and operate a large zipper; and ascend and descend stairs, sit himself, and run. Moreover, he was beginning to be able to stack eight cubes, identify dissimilar items, use a variety of words, verbally describe his activities, use buttons and shoe laces, and ride a tricycle and kick and throw balls. Qualitatively, Brian continued to display some difficulties with verbalization and motor coordination, but he was friendly, cooperative, and was able to engage in a wide variety of activities despite his physical impairments. Ms. Daniel indicated that Brian's right heel surgery provided better foot placement and knee alignment, and that the

child had outgrown his short leg brace; her report implies that Brian's past problems with poor balance and frequent falling might be substantially eliminated by a properly fitted brace and the heel surgery.

This record was submitted to Dr. Gunter Haase, a board-certified neurologist and psychiatrist, and Professor of Neurology and Director of the Department of Neurology of the Pennsylvania Hospital. Dr. Haase stated that the medical findings support the diagnoses of mental retardation, right hemiparesis, spastic weakness of the right side, and developmental delay. All impairments are, however, relatively mild. Specifically, it was his medical judgment that the child had no impairment which satisfied the requirements of the sections of the Listing of Impairments with respect to neurological, or mental and emotional disorders. He also indicated that the child has no impairment or combination of impairments which equals the requirements of any section. (Exhibits 26, 30)

Mr. Zebley certified that Brian "has easily observed disabilities in his coordination, comprehension, speech, learning ability, and physical abilities." Compared with his other children, Brian is "noticeably slower" in all such areas. On the other hand, his affidavit indicates that the child can walk without assistance, use stairs, speak and communicate understandably, and is able to learn (Exhibit 31). An earlier document (Exhibit 6) states that Brian attends school daily from eight in the morning and til 3:30 in the afternoon, then spends the balance of the day playing with toys and other family members, and watching television.

This record shows that Brian Zebley has significant limitations compared with other children of his age. However, physically he is able to walk, use stairs, and even run;

while he cannot engage in these activities to the extent and for the time expected of an unimpaired child, he can do them to a substantial degree. Similarly, the record establishes that Brian is somewhat slow to learn, has speech impairments, and lags behind his peers in attaining developmental milestones. But the July, 1982 psychological evaluation establishes that developmental delay is not as great as one-half his chronological age except as to self/help and gross motor skills, and even as to them, development is continuing apace.

Considering the activities Brian is able to engage in, and comparing the July, 1982 Elwyn Institute evaluation with that administered in July, 1981, the undersigned concludes that Dr. Haase's assessment is correct, substantiated by the preponderance of the record. Accordingly, the Administrative Law Judge concludes, that the record does not establish the existence of any impairment or combination of impairments which meets or equals the requirements of any section of Listing of Impairments at Appendix 1. In reaching this conclusion, the undersigned particularly considered Sections 100.00 (growth impairment), 102.00 (special senses and speech), 111.00 (neurological), and 112.00 (mental and emotional disorders). Although Mr. Hunter skillfully and forcefully argues that Section 112.05 applies in this case, the undersigned is persuaded that the child's physical impairments do not impose a significant restriction of function or developmental progression as required by that section.

Accordingly, the undersigned concludes that claimant's disability, as defined by the Social Security Act, ceased. In accord with due process requirements, however, the effective date of cessation is June, 1982, rather than April, 1982 as originally determined, and the child's eligibility for supplemental security income thus terminates on August 31, 1982.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. Brian Zebley was born July 13, 1978, the natural child of John Zebley.
2. Based on an application filed September 12, 1980, the child was granted Supplemental Security Income benefits.
3. The record reflects complaints and treatment of exertional and non-exertional impairments, chiefly congenital brain damage with spastic right hemiparesis, mental retardation, developmental delay, eye problems and musculoskeletal impairments on the right.
4. The record does not establish the existence of any impairment or combination of impairments of a level of severity which, as of June, 1982, meets or equals the requirements of any section of the Listing of Impairments at Appendix 1.
5. The claimant was not under a disability as defined by the Social Security Act from June, 1982 onward, through the date hereof.
6. The claimant was first informed by the Administration that disability ceased in June, 1982.

DECISION

It is the decision of the Administrative Law Judge that, based on the application filed September 12, 1980, claimant's disability ceased as of June, 1982, and his eligibility for supplemental security income terminated August 31,

1982, pursuant to Sections 1614 and 1631 of the Social Security Act.

January 26, 1983

Date

JOHN W. ENNIS, JR.

John W. Ennis, Jr.
Administrative Law Judge

**DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS**

DECISION

**IN THE CASE OF
MARGUERITE LOVE FOR
JOSEPH LOVE JR.**
(Claimant)

Claim for
**Supplemental Security
Income (Child)**

199-52-7659

(Wage Earner) (Leave Blank if same as above) (Social Security Number)

This case is before the Administrative Law Judge on a request for hearing. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits, the testimony at the hearing and arguments presented.

ISSUES

The issue before the Administrative Law Judge is whether the claimant is disabled under section 1614(a)(3)(A) of the Social Security Act. The Act defines "disability" as the inability to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment(s) which can be expected to either result in death or last for a continuous period of not less than 12 months or, in the case of a child under the age of 18, if he or she suffers an impairment of comparable severity.

The specific issues are whether the claimant, a child under the age of 18, is under a "disability" and, if so, when such disability commenced and the duration thereof.

**APPLICABLE REGULATIONS AND EVALUATION
OF THE EVIDENCE**

Pursuant to the Act, the Secretary has established Social Security Administration Regulations No. 16. Section 416.923 of the Regulations provides that a child under age 18 is disabled if he or she (a) Is not doing any substantial gainful activity; and (b) Has a medically determinable physical or mental impairment(s) which compares in severity to any impairment(s) which would make an adult (a person age 18 or over) disabled. This requirement will be met when the impairment(s) —

- (1) Meets the duration requirement; and
- (2) Is listed in Appendix 1 of Subpart P of Regulations No. 4; or
- (3) Is determined to be medically equal to an impairment listed in Appendix 1 of Subpart P of Regulations No. 4.

The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity. The Listing of Impairments consists of Parts A and B. In evaluating disability for a person under age 18, Part B will be used first. If the medical criteria in Part B do not apply, then the medical criteria in Part A will be used.

In applying the criteria outlined above, the Administrative Law Judge concludes that the claimant does not have any impairment which is listed in Appendix 1, Subpart P, Regulations No. 4. Furthermore, he does not have an impairment or combination of impairments which is medically equal to an impairment listed in Appendix 1. Accordingly, it must be found that the claimant, who has not attained age 18, is not disabled within the meaning of the Social Security Act.

The claimant was born on February 26, 1973. The reports from the claimant's school district showed that he was originally begun in regular class work although it was recommended in 1979 that he be placed in a learning disabled classroom. In the regular classroom situation he failed first grade three times and was begun in a special learning class in 1981 but was unable to adapt to the program. With efforts to have him entered into alternate special education classes failed in early 1983 he was begun in the homebound instructional program. As of April 1983 Mr. Patrick Ahern, the director of special education, stated that he continued to receive instructions at home since no placement had been worked out, (Exhibits 26, 27).

At the hearing the claimant testified that he used to go to Columbus school but now has a tutor who comes to his house. As part of his school work he reads the Dinosaurs reading book and was able to identify the characters in the book and spell short words. He was able to perform minor addition and subtraction but could not do any problems where a digit or total was over 10. He could print and write a little in cursive. When asked to why he was no longer attending the Columbus school he stated that he was too smart for the teachers and they unable to handle him. He stated that he was hated by the other children in the school and they physically abused him. He is able to ride a two wheel bike, likes to color and sometimes gets in fights with children on his street.

The claimant's mother testified that the Columbus school was a special education class but they could not cope with the claimant because they could not give him enough of their time and he was constantly running about. He spent one year in kindergarten and three years in first grade. He usually goes to sleep at two [sic] a.m. and wakes

at 6 a.m. He has been unable to sit still and climbs on top of things constantly. He constantly slides across the floor and runs up and down steps. He fights with his six year old brother. He has a short attention span and does not always finish watching a whole television program. He is very good at drawing but only does it for about five minutes. He can work puzzles containing thirty to sixty pieces. He gets upset easily and when left with a sitter will cry. He will argue with her and is too fearful to leave the bathroom door closed because he does not like to be left alone. He becomes depressed and moody. He cannot write a sentence on his own but can copy it. He must sleep on a mattress on the floor because he is active while he sleeps. He is not allowed to play outside because he is always getting into fights with others. His tutor has difficulty getting his attention, they argue and his mind wanders. He will not stay seated during the tutoring, constantly jumping up, grabbing at papers and frustrating his tutor. The claimant had been on medication for hyperactivity but she discontinued giving it to him because it was not doing him any good. He has been treated by Dr. Ivans on and off over the last four years. He helps with the dishes occasionally and takes of his personal needs normally.

The medical evidence shows that the claimant had received outpatient treatment at the Crozier-Chester Hospital as early as November 1976 for a moderate bilateral conductive hearing loss but he had excellent speech discrimination. It was felt that he had middle ear pathology possibly secondary to a fluid build up. He was also seen for vague abdominal pains, complaints of joint pain, shaking and bronchitis, (Exhibit 5). Dr. Steven Fischer reported in August 1981 that the claimant had bilateral serous otitis and underwent surgery in April 1980 for the implantation of tympanic ventilation tubes. By July 1981 the tubes were

extruded and the ears appeared to look well. Testing showed his hearing to be normal with only a mild conduction deficit and again he had excellent speech discrimination, (Exhibit 10).

The claimant was examined by Dr. Frank Rosenberg on September 1, 1981 and appeared thin but well developed. It was stated that he had some asthma but hyperactivity was his main problem. He was receiving no medication for the asthma problem. A chest x-ray was normal as were pulmonary function studies. An electrocardiogram showed signs of arrhythmia. He was felt to have no chronic lung dysfunction or any current symptomatology, (Exhibit 11).

Dr. Samuel Ivens reported that he had treated the claimant between March 1979 and May 1981. He described the claimant as a hyperkinetic child who performed satisfactorily in a learning disabled classroom. Weschler IQ testing showed him to range between 93 and 97. Motor-visual perception age was greater than his chronological age. Physical examination was normal. He had no limitation on his ability to care for himself, understand and follow directions or perform simple calculations. He was able to read and write appropriately with his age and grade level and could use public transportation, (Exhibit 9).

However, in August 1982 Dr. Ivens reported that the claimant had a normal IQ but was nine and one half years old with unusual behavior and still in kindergarten after four years. He was able to care for his needs at an age appropriate level and engaged in normal activity for a nine and one half year old. He appeared bright but loquacious. He diagnosed the claimant as suffering organic brain syndrome with a psychiatric and neurological impairment. The psychiatric impairment was described as adjustment

disorder with mixed disturbance of emotion and conduct. The neurological impairment was severe hyperkinesia and involuntary movements with visual/motor misperception, (Exhibit 18). On examination the claimant was described as being thin and pale. There were occasions of uncontrolled athetoid movements. There were no sensory abnormalities but he had difficulty with bilateral hand stereognosis, difficulty with visual/motor perception and hyperreflexivity, (Exhibit 26).

The claimant was examined by Dr. John Liebert, a psychologist in September 1981. The claimant was described as being very distracted during the testing, moving about and humming. His IQ was tested as 99 in the average range. Subtesting showed possible learning disorder but he had above average recall of information, attendance and concentration. He had a low symbol matching accuracy which was indicative of a visual motor perceptual problem which was also suggested by the Bender-Gestalt testing, (Exhibit 13, 24).

The claimant had been referred to Dr. Elinor Weeks, a child psychologist, who reported in February 1982 that he suffered from adjustment disorder with mixed disturbance of emotion and conduct. He was described as being very impulsive, apprehensive and a poor learner. He was unable to relate with his peers, control his aggressions easily or learn. He was appropriate in his ability to care for himself, understand the spoken work, follow instructions and do simple calculations. He had a poor ability to read but could write. He was being treated with Cylert, (Exhibits 16, 17).

The claimant also underwent psychological evaluation under Jolene Sims in June 1982. He stated that in a school classroom the claimant was aggressive both verbally and

physically, disruptive and uncooperative in his behavior. During the testing he chatted excessively. On the non-academic testing he was alert, interested and motivated, but on the academic testing he was lethargic, apathetic and evasive because he felt threatened and inadequate. Weschler Child IQ testing showed him to be in the 98-120 range, the average-high average range. There were no signs of any perceptual impairment. He had strengths in using words and abstract associative reasoning. He had reduced practical knowledge and common sense. He scored high average to superior on performance tests using visual comprehension and discrimination and spatial perception. There were some remnants of a visual/perception deficit which had been present in the past. It was felt that his perceptual problems had diminished considerably. He exhibited severe emotional stress secondary to his academic failures which were felt to be the cause of his poor adjustment in the learning disabled program, (Exhibit 26).

The medical evidence does not establish that the claimant has any severe physical impairment. The physical testing has been essentially negative with no indication of any significant neurological or pulmonary impairment, (Exhibit 5, 11). The evidence establishes that the claimant has no significant residual hearing problem, (Exhibit 10). Dr. Ivens does state he has neurological impairment due to severe hyperkinesia and involuntary movements but there were no clinical findings by either Dr. Ivens or a neurologist to support the existence of any significant neurological impairment. No such neurological involvement was mentioned in any of the other examinations, it was commented upon during any of the psychological testing. The most recent psychological testing of June 1982 did not show any significant continuing performance difficulty because of a

neurological problem, (Exhibit 26). Additional time was given for submission of a report of a neurological examination the claimant was stated as having undergone but no such report was received. The statements in the record and the testimony of the claimant and his mother as to his ability to perform normal activities around the house and take care of his personal needs did not reflect any significant neurological problems.

The evidence establishes that the claimant has a normal to high average intelligence. The evidence does show that he suffers from hyperactivity with an adjustment disorder with a mixed disturbance of emotion and conduct. However, the evidence does not show that this is severe enough to meet or equal any of the Listings of Impairments contained in Appendix I of Subpart P of Regulation No. 4. The severity of the impairment, which is indicated by Dr. Ivens in Exhibit 18, is not consistent with his earlier statements in Exhibit 9 that the claimant was able to perform satisfactorily in class, (Exhibit 9). A great deal of effort has been made to fully develop the record but the evidence which has been obtained does not establish the condition is severe enough to meet or equal any of the Listed Impairments. The claimant's actions and demeanor at the hearing were not consistent with the severity of his emotional and behavioral problems as testified to in the record. He was able to sit tolerably still during the hearing however he fidgeted somewhat in his seat. He was able to understand all the questions posed to him and responded appropriately.

The medical evidence of record was submitted to Dr. Margaret A. Friel, a board-certified pediatrician and child psychiatrist, who is a medical advisor to the Secretary. It was Dr. Friel's opinion that based upon the evidence of record, no significant neurological impairment had been unequivocally established. She noted that while Dr. Ivens

had described a slight or minimal sensory change, in the same report he stated that the claimant had hyperreflexia with ewthetoid movements. This she felt was conclusive and difficult to evaluate in the absence of other findings. The more recent neurological examinations made no mentions or abnormal findings in these areas. It was her opinion that the claimant did not have any neurological or physical impairment which would be of sufficient severity to meet or equal any of the impairments listed in Appendix 1 of Subpart P of Regulation No. 4.

Dr. Friel did believe that the diagnoses of adjustment disorder with mixed disturbance of emotion and conduct (DSN 309.40) and the diagnosis of attention defect disorder secondary to family stress were established by the evidence of record, especially the reports from Dr. Weeks in Exhibits 16 and 17. She described the claimant as having average intelligence with an academic handicap of a learning disability and the emotional handicaps associated with the psychiatric diagnosis. It was her opinion that on the basis of the evidence presented in the file the overall severity of the total situation was moderate, that is a rating of 3 on a scale of 1-5. She noted that he was able to function in a class for the learning disabled, such that it had not been necessary to confine him to a more restrictive environment, such as the Eastern State school or Hospital. He was described in the record as a bright child who was able to learn and would be able to pick up quickly when taught on the right level given adequate opportunity. She noted that in the testing he related comfortably to the various examiners and while he functioned emotionally at home and at school with problems of adjustment these were not shown to be of a magnitude which would meet or equal any childhood listing in Appendix 1. While there was no doubt that he was compromised academically and

socially in her opinion the compromise did not meet or equal the severity required under the Listings for any impairment, (Exhibit 30).

The Administrative Law Judge finds that, for the reasons discussed herein, and the opinion of Dr. Friel the claimant has not had a physical, mental or emotional impairment of sufficient severity to meet or equal any of the Listed Impairments in Appendix 1, Part B, Subpart P of Regulation No. 4 and thus cannot be found disabled, as such is defined for a child under age 18.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant was born on February 26, 1973 and is a child under age 18.
2. The medical evidence establishes that the claimant has adjustment disorder with mixed disturbance of emotion and conduct and attention defect disorder secondary to family stress.
3. The medical evidence further establishes that the claimant does not have an impairment or combination of impairments either listed in or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4 (20 CFR 416.925 and 416.926).
4. The claimant was not under a "disability" as defined in the Social Security Act, at any time through the date of this decision (20 CFR 416.923).

DECISION

It is the decision of the Administrative Law Judge that, based on the application filed on June 5, 1981, the claimant is not eligible for supplemental security income under sections 1602 and 1614(a)(3)(A) of the Social Security Act.

/s/ Linda M. Bernstein
LINDA M. BERNSTEIN
Administrative Law Judge

June 10, 1983
Date

**DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS**

DECISION

In the case of	Claim for
MARY RAUSHI FOR	Continuance of Supple-
<u>EVELYN RAUSHI</u>	mental Security Income
(Claimant)	<u>(Child)</u>
<u>(Wage Earner) (Leave</u>	<u>171-60-9163</u>
blank is same as above)	(Social Security Number)

This case is before the Administrative Law Judge on a request for hearing. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits, the testimony at the hearing and arguments presented.

ISSUES

The issue to be determined is whether the claimant continues to be disabled under section 1614(a)(3)(A) of the Social Security Act. The specific issues are whether the claimant's disability has ceased, and if so, when.

**APPLICABLE REGULATIONS AND EVALUATION
OF THE EVIDENCE**

Pursuant to the Act, the Secretary has established Social Security Administration Regulations No. 16. Section 416.994(c) of Regulations No. 16 provides that if an individual is under age 18, a finding that his or her disability ended will be in the earliest of the following months —

- (1) The month the impairment, as established by current medical evidence is not an impairment listed in Appendix 1 of Subpart P of Regulations No. 4 or is not equal to a listed impairment;
- (2) The month in which the individual demonstrated the ability to engage in substantial gainful activity (following completion of a trial work period).

The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity. The Listing of Impairments consists of Parts A and B. In evaluating disability for a person under age 18, Part B will be used first. If the medical criteria in Part B do not apply, then the medical criteria in Part A will be used.

The evidence of record shows that the claimant was found to be eligible for supplemental security income as a "disabled child" beginning August 13, 1979. However, it was determined that disability ceased as of October 1981. (It is the policy of the Social Security Administration that the month of cessation will ordinarily be the month that the claimant is informed that the Social Security Administration plans to find that disability has ceased. The question to be resolved is whether the claimant's impairment(s) singly or in combination continue to meet or equal those impairments listed in Part B of the Listing of Impairments at the time disability was found to have ceased.

In applying the criteria outlined above, the Administrative Law Judge concludes that since November 1981, the claimant has not had an impairment which is listed in Appendix 1, Subpart P, Regulations No. 4. Furthermore, since that date, she has not had an impairment or combination of impairments which is medically equal to an

impairment listed in Appendix 1. Accordingly, it must be found that the claimant, who has not attained age 18, is no longer disabled within the meaning of the Social Security Act.

Mary Raushi, the applicant, filed an application for supplemental security income on behalf of Evelyn Raushi, the claimant, on August 13, 1979. The claimant was born on December 30, 1974. The applicant is the claimant's mother. The claimant was found to be disabled due to mental deficiency. It was subsequently determined that her disability ceased in October 1981. The applicant disagrees with this determination, alleging that her daughter's disability continues. Her representative is Mark Kaufman, Esquire, of Delaware County Legal Assistance.

Mary Carol Hornyak, a school psychologist, evaluated the claimant on May 21 and 22, 1981. The claimant was noted to have a history of premature birth followed by jaundice and rubella. Another early problem noted was strabismus. A Stanford-Binet test was administered in October 1978 and the claimant's IQ score was 62. A new Stanford-Binet was administered at the May 1981 evaluation and the claimant's score was 82. WEAT scores were at the kindergarten level. Difficulties were noted in motor areas, such as spatial relationship problems, and in visual perceptual areas (Exhibit 32).

Dr. C. McCormick, a pediatric neurologist, examined the claimant on July 8, 1981. The claimant had a grand mal seizure in February 1981 but her seizure disorder was now described as controlled by medication. The examination was consistent with mild mental retardation but was otherwise unremarkable (Exhibit 49).

Dr. William Frayer, an ophthalmologist, submitted a letter dated August 26, 1981. The claimant had undergone

surgery for correction of esotropia in June. When last seen on July 29 she was described as doing well and her visual acuity was good (Exhibit 51).

Dr. Steven Barrer, a neurologist, examined the claimant on October 5, 1981. The claimant was reported to be alert and oriented. She was described as friendly and cooperative. She had no difficulty expressing herself or understanding commands. Neurologic examination was entirely normal (Exhibit 33).

Dr. Lawrence Gordon, an otorhinolaryngologist, examined the claimant on September 29, 1982. The ears were normal. Voice and speech were intelligible. Hearing was normal. There were no evident functional limitations based on ear, nose, and throat examination (Exhibit 55).

Dr. William Frayer, an ophthalmologist, submitted a letter dated January 7, 1983. He noted that the claimant had received surgery for congenital convergent strabismus. She has done well postoperatively and had visual acuity of 20/20 in both eyes. There was minimal residual esotropia with no significant functional impairment. Dr. Frayer stated that he had studied Appendix 1, Subpart P, and concluded that the claimant had no impairment listed in that Appendix (Exhibit 56).

At the request of the undersigned, Dr. Tim Lachman, a neurologist, evaluated the claimant on March 14, 1983. The claimant had a history of a seizure disorder with two seizure episodes. There had been no seizures in about two years. The claimant was described as alert and cooperative. There were a few beats of nystagmus at the end of horizontal gaze to either side. Neurologic examination was otherwise normal. Dr. Lachman's impression was generalized, tonic-clonic seizure disorder, presently under good control (Exhibit 59).

Dr. Joseph Puleo, a psychologist, evaluated the claimant on March 23, 1983, also at the request of the undersigned. He administered a Wechsler intelligence test on which the claimant achieved a full scale IQ of 64, verbal IQ of 67 and performance IQ of 65. WRAT revealed a grade level of 1.4 in reading and 2.4 in arithmetic. Rorschach revealed emotional immaturity and intellectual and social impoverishment consistent with a developmental delay of two years. Rorschach was also consistent with significant latent anxiety. Dr. Puleo's impressions were developmental learning disorder, minimal brain dysfunction and mild mental retardation (Exhibit 60).

At the further request of the undersigned, Dr. John Goppelt, a psychiatrist, examined the claimant on March 25, 1983. The claimant's intelligence seemed somewhat below average but Dr. Goppelt found no evidence of a psychiatric disorder (Exhibit 61).

Interrogatories and a copy of the evidence of record were submitted by the undersigned to Dr. Margaret Friel who is a psychiatrist and a medical advisor to the Social Security Administration. Dr. Friel reviewed the evidence and concluded that the claimant had no impairment described in Appendix 1, Subpart P, Regulations No. 4, nor any impairment or combination of impairments of equivalent severity (Exhibit 62).

Interrogatories and a copy of the record were also submitted by the undersigned to Dr. Gunter Haase, a neurologist and medical advisor to the Social Security Administration. Dr. Haase reviewed the evidence and concluded the claimant had no impairment or combination of impairments which met or equalled the impairments listed in Appendix 1, Subpart P (Exhibit 64).

A hearing had been held in Philadelphia, Pennsylvania on February 16, 1983. The claimant, to the undersigned, appeared friendly and cooperative. She interacted in an open manner. She named her favorite television program and mentioned several household chores which she performs. The applicant testified that the claimant bathes and dresses herself. She said that the claimant occasionally has a temper tantrum.

The claimant, who is eight years old, of course has not been engaging in substantial gainful activity. She has a severe impairment in the form of mild mental retardation. In order to be eligible for supplemental security income, she must have an impairment described in Appendix 1, Subpart P, Regulations No. 4, or an impairment or combination of impairments of equivalent severity.

The section the Appendix applicable to this case is section 112.05 which deals with mental retardation. A child meets that section if she has an IQ of 59 or less or an IQ of 60-69 and a physical or other mental impairment imposing additional and significant restriction of function or developmental progression. The claimant's IQ, based on the latest psychological evaluation, falls in the 60-69 range. However, the evidence does not establish that she has a significant impairment other than her mild mental retardation. Her congenital strabismus has been surgically corrected. She has no significant sensory impairment. Her seizure disorder is well controlled on medication. She has had no seizure in more than two years. Accordingly, the undersigned concludes that the claimant's condition is not as described in section 112.05, Appendix 1. The claimant likewise does not have an impairment or combination of impairments of equivalent severity. These conclusions are supported by the views of Drs. Friel and Haase which are summarized above.

Dr. Barrer examined the claimant on October 5, 1981. His neurologic examination was negative. At that time it was clear that the claimant's seizure disorder was well controlled and her intellectual functioning had improved. A conclusion that the claimant was no longer disabled as of October 5, 1981, would thus be reasonable. However, it is the policy of the Social Security Administration, subject to exceptions which are inapplicable to this case, that disability will not be found to have ceased prior to the month in which notice of planned cessation is provided. In this case that month was November 1981. Accordingly, the undersigned finds that the claimant's disability is deemed to have ceased in November 1981.

Claimant's representative has raised the issue of whether the regulatory provisions requiring the claimant to meet or equal the impairments in Appendix 1 are unlawfully more restrictive than intended by Congress. The Social Security Regulations are binding on the undersigned who has no jurisdiction to declare them invalid. Challenges to such regulations must be raised in a more appropriate forum.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant was found to be disabled within the meaning of the Social Security Act as of August 13, 1979.
2. The claimant's impairment is mild mental retardation.
3. The claimant has not engaged in substantial gainful activity since becoming eligible for supplemental security income.

4. The medical evidence establishes that since November 1981, the claimant has not had an impairment or combination of impairments listed in or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4 (20 CFR 416.925 and 416.926).
5. The claimant's disability ceased on November 1981 (20 CFR 416.994(c)).

DECISION

It is the decision of the Administrative Law Judge that the claimant's eligibility for supplemental security income under sections 1602 and 1614(a)(3)(A) of the Social Security Act, ended effective January 31, 1982, the end of the second calendar month after the month in which the disability ceased.

/s/ Malvin B. Eisenberg
 MALVIN B. EISENBERG
 Administrative Law Judge

July 27, 1983
 Date

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 83-3314

BRIAN ZEBLEY, ET AL., PLAINTIFFS

VS.

MARGARET HECKLER, ET AL., DEFENDANTS

DEPOSITION OF: BERTRAND KUSHNER, M.D.
 TAKEN BY: PLAINTIFFS
 DATE: JULY 20, 1984, 9:30 A.M.

APPEARANCES:

DELAWARE COUNTY LEGAL ASSISTANCE
 ASSOCIATION
 BY: MARK KAUFMAN, ESQUIRE
 FOR - PLAINTIFFS
 JOHN E. NEWTON, JR., ESQUIRE
 FOR - DEFENDANTS

[2] BERTRAND KUSHNER, M.D., called as a witness, being sworn, testified as follows:

DIRECT EXAMINATION

BY MR. KAUFMAN:

- Q. State your name for the record.
- A. Bertrand Kushner, Dr. Bertrand Kushner.
- Q. And you are a physician; is that correct?
- A. Correct.

Q. A medical doctor?

A. Correct.

Q. Do you have any particular specialty?

A. Internal medicine and gastroenterology.

Q. And perhaps you can just briefly describe your background education and career.

A. University of Pennsylvania undergraduate, Jefferson Medical College, internship at Albert Einstein Southern Division of Philadelphia. Residency, Jefferson Medical College Hospital. In practice in Harrisburg since 1960.

Q. That is a private practice?

A. My private practice.

Q. And, what is your position if any with disability determinations?

A. I have been a reviewing physician for disability since 1962.

. * * * *

[21] Q. My question was, the statement was that they were impairments which were not "severe", they were nonetheless impairments and there were a multitude of them in addition to the IQ but none of them were singularly severe.

A. This would not meet the listing.

Q. I'd like to talk briefly a bit about then, since you have a listing in front of you, 112.04 of the listing.

A. Functional nonpsychotic disorders.

Q. Yes, that's correct.

Now, I believe it was your testimony earlier that each and every element of a listing must be met; is that correct?

A. That's correct.

Q. In the opening paragraph of that subsection 112.04, it states in part: "Marked restriction in the performance of daily age appropriate activities, constriction of age appropriate interests, deficiency of age appropriate self care skills and impaired ability to relate to others."

Must the medical evidence document marked restrictions in each of those categories?

A. Yes.

Q. So that a marked restriction in several of those [22] categories with restrictions that are not "marked" in other categories would not meet the listing?

A. Would have to meet every one of them, yes.

Q. What is a marked restriction in distinction from a restriction?

A. That's a judgment based on the—that is a judgment that a physician would have to make based on the evidence.

Q. Is there any standard schedule, scheme, rule for evaluating where a restriction becomes marked and when it is less than marked?

A. I don't know of any.

Q. I would like to just come back briefly again to this notion of equivalence, which is slippery—at least my brain has difficulty coping with it. Unfortunately, the example we imposed you said there was no need for the notion of equivalency because there was a listing; is that correct?

A. Yes.

Q. Assuming that we have a child with a functional nonpsychotic disorder with marked restrictions in their age appropriate activities and interests, inability to relate to others, impairments of their self care skills but somehow less than marked so that it doesn't meet the listed impairment; is that correct?

A. Correct.

Q. Who in addition had the orthopedic problem you described for our hypothetical child, John Doe. Can you using that or those givens, describe how the concept of equivalence would or would not work in such a case?

A. Equivalence really—I think you are trying to equate—or you sound like you are trying to equate equivalence with combination.

Q. Maybe I was trying to do that.

A. Two different things. That's not my concept. That is not the concept I have of equivalence. The concept I have of equivalence is that the medical problem is severe as the listings describe but there is no listing to fit it into. The listings, as far as I can determine, do not cover a hundred percent of medical problems. There has to be some medical problem that is going to come up that doesn't fit in any of the categories we have. And if we determine it is as bad as one of these listing but we don't have a listing for it, then we would say it is equivalent to. A combination and equivalence are not the same.

Q. So in this hypothetical I gave you, equivalence is not an appropriate concept, but a combination is; is that correct?

A. Right.

Q. Let's move on then to this concept of combination. Can you describe to me—

A. There is no—we have no listing of severity or [24] medical impairment that includes a combination other than when they are actually described in the listing itself as that one case was.

Q. So in a case such as that, how would you deal with that?

A. We would say it does not meet the listings.

Q. And that equivalence—it does not equal the listing?

A. Did not equal the listing.

Q. Another question in regard to combination. Am I correct in my understanding that no combination of impairments, regardless of the number and variety of impairments which—none of which are themselves severe impair-

ments can be utilized to meet or equal the listed impairments; is that correct?

A. In general, it's correct. There are some specific cases where there may be two impairments neither of which meet the listings but one impacts so much on the other that it may equal what we would consider equal the listings. These are very rare, I would say, unusual-type cases.

Q. Can you give me some sense of how much or how frequently the concept of equivalent is applied in cases of mental disability?

A. I would say it would be unusual to have a mental claim adjudicated as equaling the listings.

Q. And again, can you give me some sense of—apart [25] from cases involving mental retardation under subsection C of 1205 and 11205, the frequency with which combinations of impairment are employed in meeting or equaling the listing?

A. It would be very unusual.

Q. In both cases of children or adults?

A. Correct.

Q. Now, to what extent can you substitute the severity of a particular symptomology or clinical finding for the failure of the medical evidence to document meeting each and every aspect of a listing?

A. In order to meet the listing, they have to meet each and every aspect.

Q. So your answer to my question would be that you can't?

A. Can't.

Q. If I recall, I started out the last line of questioning talking about adults and we shifted back and forth between adults but it had been your testimony that the concept of meeting and equaling was the same for adults and

children with regard to this phase of the evaluation disability; is that correct?

A. That's correct.

Q. Are there differences between children and adults in terms of this concept of combination of impairment at this stage of the evaluation?

[26] A. No.

Q. Just to clarify some things in my mind, I would like to move beyond a bit of the listing notions. Assuming an adult does not meet or equal a listed impairment, there is further evaluation; is that correct?

A. Yes.

Q. And, can you describe that further evaluation?

A. Well, as far as the medical — as far as the physicians are concerned, we must determine what we call residual functional capacity, which is a description of what that person's capable of doing.

Q. And may I take it by implication then that an individual who does not meet or equal a listed impairment is ipso facto capable of doing something?

A. Capable of doing something? I guess I can agree. Capable of doing something.

Q. Although he may or may not be capable of working?

A. Correct.

Q. Depending on how much of something he can do or she can do.

Now, in the context of doing this residual functional capacity analysis, you were again considering then the medical evidence; is that correct?

A. Based on the medical evidence.

Q. In the context of doing that analysis, can you con-[27]sider the particular severity of certain clinical findings or symptomology even though not all the elements of a listed impairment are met?

A. Exactly what we do.

Q. And conclude that the individual cannot be expected to work?

A. No. Physicians don't make that decision.

Q. I am sorry. The physician would —

A. Determine what the person is medically capable, medically capable of doing.

Q. Which could be quite limited?

A. Could be.

Q. Now, in the context of doing the residual functional capacity analysis from the physician's standpoint to determine what the individual's medically capable of doing, can you combine the impairment that we had previously described —

A. Use all the medical you have to reach that — whatever conclusion you reach based on all the medical facts in the case.

Q. So that when I asked you — when you testified that — earlier that combinations of impairments were not frequently employed in the context of mental disability claims other than the mental retardation claim, would it be your testimony that they are frequently employed under the —

[28] A. If there's more than one medical problem, then it's considered in determining RFC, certainly.

Q. And you testified that no combination of impairments, whatever multitude, none of which were themselves severe could lead to the meeting or equaling listed impairment ordinarily; is that correct?

A. That's correct.

Q. Would you consider those impairments in the context of discerning what the individual could do residually?

A. Well, if you are saying they are not severe by definition, they don't impact on his residual function. If you are talking about non severe impairments, even if

there are 20 of them, they would not impact on residual functional capacity. By definition we are saying that a non severe impairment does not —

Q. Would you consider impairment that in your medical judgment some of which you believe were severe and some of which you believed were not severe in combination with each other?

A. Well, we considered the severe impairments.

Q. Only the severe impairments?

A. Only the severe impairments.

Q. May I take it then that in the case of an adult who tested an IQ of, say, 70 and have had the orthopedic problems you previously described related to the child, John Doe —

[29] A. An adult with those?

Q. An adult with those problems would not meet the listed impairment?

A. I would — I would say would not meet the listed impairment.

Q. And the concept of equivalence again would not be applicable?

A. Correct.

Q. But that the combination of those impairments would be considered by the medical staff with a view to determining what remaining work — what remaining activities the individual medically could be expected to do?

A. Well, I really have to have a better description of the orthopedic problem before, you know, before —

Q. I am not asking you for an opinion on what the person — but you would consider it to determine what they could do?

A. If the orthopedic problem was considered severe, it would be involved in the determination of RFC.

Q. And at least hypothetically the orthopedic problem together with the IQ could be severe enough to restrict that individual's activities very greatly?

A. Could be.

Q. Now, in the case of a child with that combination, IQ of 70 rather than 64 but otherwise the same, that child [30] would not meet the listed impairment?

A. They would not meet the listed.

Q. And again, the concept of equivalency would not place?

A. No.

Q. Assuming for the moment that the orthopedic problem was a severe problem, where if at all would there be consideration of the combination of those impairments for that child?

A. With an IQ of?

Q. 70.

A. It would not meet the list.

Q. And there would be no consideration, therefore, for that combination?

A. We don't determine residual functional capacity on children.

* * * * *

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

NO. 83-3314

BRIAN ZEBLEY, ET AL., PLAINTIFFS

vs.

MARGARET HECKLER, SECRETARY OF HEALTH
AND HUMAN SERVICES, DEFENDANT

Oral deposition of MAURICE PROUT, Ph.D., taken on behalf of the Plaintiffs, in the Law Office of JOHN NEWTON, ESQUIRE, 3535 Market Street, Philadelphia, Pennsylvania, on Thursday, July 19, 1984, commencing at or about 1:45 P.M., before Lorraine D. Connell, Registered Professional Reporter-Notary Public.

[6]

* * * * *

I've been at Hahnemann University Medical School in the Department of Psychiatry since 1975 to present on a full time basis.

I am an adjunct professor at the University of Pennsylvania in the Department of Psychiatry.

Q. And, what is your position here with Social Security?

A. As a consultant.

* * * * *

A. I've been doing it for seven years.

* * * * *

[9] Q. Can you briefly describe what those duties are?

A. Sure.

What we do is look at cases that come in on a second tier review, and we make a [10] decision on whether those cases have been adjudicated properly, in terms of what was done on what is referred to as a first tier review.

This is done on a sample basis, and, again, you know, there would be times when a case has been, for instance, allowed, and we make a determination that the case should not have been allowed, that the judgment was in error, or where a case was denied, and we make a determination that the evidence indeed supports an allowance, or, the third option would be when a decision has been made either to allow or disallow the case, and we decide that the medical evidence is not substantial enough to render a decision.

Q. Are these part of some regular quality review program?

A. Right.

* * * * *

[17] In terms of the concept of meeting or equaling a listed impairment, is there any difference between the evaluation of children and adults?

A. No, there isn't.

Q. So, we can safely assume that when we talk about what those concepts mean, and the kinds of evidence that are included, that it is true of both adults and children?

A. Sure.

I should also point out that with regard to the equals concept, it is hardly ever utilized in mental cases.

Q. I was about to get to that.

A. Sure.

Q. But, maybe we'll just put that off for a moment, and come back to that.

A. Okay.

Q. Can you tell me what meeting a listed impairment means?

A. Sure.

Q. What is that?

A. It depends on what the impairment is, and in the case of the twelve hundred categories, for instance, as it's germane to this particular case—

* * * * *

[23] Q. Now, in that scheme of determining whether someone meets a listed impairment, suppose that although each and every element was not met, the level of impairment with regard to the other elements was by any medical or lay standard that you would care to name, very severe, does the concept of meeting, just the concept of meeting a listed impairment, have a means for allowing for particular severity of certain restrictions?

A. No.

I think the law is quite clear as it is stated.

In order to meet a listing, these are the criteria.

* * * * *

[27] A. The concept would be that the evidence doesn't meet a listing, but there's a combination of maladies or disabilities that the individual has, and in combination, someone makes a determination that, indeed, it's severe enough to equal the intent of the listing.

Again, it's rare that it's utilized in the mental categories.

I understand that it's much more frequent in cardiac cases, orthopedic cases and the rest of it.

It will be utilized in the mental listings contingent on when you use the P.R.F. form, that you have a constellation of three in effective intelligence, three in affective disturbance and a three in reality context.

The three and the three and the three won't meet anything, since the individual is not severely impaired in intellectual function, he's not severely impaired in affective function—I shouldn't say that, I'm sorry.

Let me correct myself.

He is severely impaired.

Doesn't meet the concept, but clearly when you put all of this material together, [28] the individual overall is severely impaired, and the concept would be with the three and the three and three constellation that he equals the intent listing.

That's the only time that you'll get an equals on a mental case.

Q. I see.

So, with regard to the mental retardation sections—

A. (Interposing) the 1205 instance?

Q. The 1205 instance and the one hundred and 1205 instance, the individual with an IQ between sixty and sixty-nine, however functionally impaired they might be, either does or doesn't have a significant other restriction of function, and there's no room for equivalence; is that what you're saying?

A. That's quite correct.

Q. I'd like to talk about that a little bit more, that phrase other.

It's phrased slightly different, if I recall correctly, between the adult and the child listing.

You might refer to those.

* * * * *

[35] Q. So, the problem would be true of children as well?

A. Sure.

Q. Does it go the other way around as well?

You've said that, if I understood you correctly, that distinguishing poor performance because of mental retardation from a poor performance because of a functional disorder like an affected disorder, depressive disorder, can be difficult, can I then safely assume that the distinguishing—

A. (Interposing) I don't think that it's difficult. I think you have to be clinically astute. I don't think it's difficult.

Q. I guess my question was really trying to come at it from the other way.

Assuming you had a child who you accept as, in fact, being mentally retarded with conduct and behavior problems, depression—

A. (Interposing) yes.

Q. —how do you go about distinguishing whether that is an other quote other functional limitation, [36] or whether it's really just a part of the mental retardation?

A. It becomes more difficult to do it with children than with adults.

You don't have a large store of premorbid history with children.

The brain, for the most part, isn't fully functional with kids in terms of being able to absorb a variety of experiences and function in a variety of capacities.

What you may be picking up is a developmental lag, for instance, in a kid who four years from now will show up with a normal IQ.

But, that is not what you're picking up initially.

Or, what you may pick up is something like an adjustment disorder in childhood.

What is the divorce rate these days, about fifty percent in the United States.

All kids, I would guarantee, go through a period of time, and they may indeed be—let's take a kid who's five

years old, who was previously toilet trained, for instance.

* * * * *

[55] Q. And, I asked you if a particular severity in one aspect of their mental condition could be considered with a view towards whether they met the listing—

A. (Interposing) correct.

Q. And, I believe your answer to that question was no—

A. (Interposing) right.

Q. Okay.

Taking that sequence of thoughts one step further, can the particular severity of a particular aspect of the mental disorder, in a case which did not meet the listing because it failed the requisite level of severity of some other aspect of the listing, be taken into account in determining equivalence?

A. No.

Again, we're talking about the mental listings.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 83-3314

BRIAN ZEBLEY, ET AL., PLAINTIFFS

—
vs.

MARGARET M. HECKLER SECRETARY OF HEALTH
AND HUMAN SERVICES, DEFENDANT

Deposition of JEROME E. SHAPIRO, M.D., taken on Friday, August 10, 1984, at 2:00 p.m., at the Social Security Administration, Dickinson Building, 1500 Woodlawn Drive, Woodlawn, Maryland, before Diane D'Argenio, Notary Public.

* * * * *

[2]

STIPULATION

It is stipulated and agreed by and between counsel for the respective parties that the filing of this deposition with the Clerk of Court is hereby waived.

JEROME E. SHAPIRO, M.D.,

Q. Why don't you state your name and address for the record.

A. My name is Dr. Jerome E. Shapiro, 5725 Ridgedale Road, Baltimore, Maryland, 21209, my home address. One East University Parkway, No. 110, Baltimore, Maryland, 21218 is my office address.

Q. We're here on a deposition which is just part of what's called the discovery process of law, and I suppose it's called a discovery process because that's what I'm trying to do, just learn something about how the agency approaches the issue of evaluating medical evidence in child cases. I don't come here with any [3] particular ax, in a sense of precommitment to any particular answer. It's just an opportunity for you to tell me from your experience how the agency functions. In order to do that, I want to make sure that we have a very clear record so that if at any time you decide that the answer wasn't complete enough or was misleading in some fashion, just interrupt and correct it. The point here is to get as clear a record of what the agency is doing as possible, not to judge or evaluate, but that's up to the Court rather than to either me or counsel for the agency. Also, if in the course of asking a question I have somehow misstated a rule or misstated your understanding of something that you had said, please correct me on that, too. I've certainly been known to do that on occasion. I don't mind being corrected.

Can you tell me what your current position here with Social Security is?

A. My current position is as a part-time contract psychiatric consultant to the medical consultant staff of the disability program, the Office of Disability, and in that capacity, I have worked with the agency for [4] approximately 20 years. My specialty is psychiatry, and so my expertise, if we want to call it that, is in the area of assessing psychiatric impairments in disability applicants. Not in determining disability, but in assessing a medical, a psychiatric impairment. I specify that—if I may amplify just a little.

Q. Please do.

A. I specify that because there is often some confusion about the term disability as opposed to the term impair-

ment, and I want to state clearly that the two are not synonymous, that the term disability involves other factors besides medical factors, whereas impairment implies a medical judgment about severity of a particular condition.

Q. So your task is to advise the agency with regard to the issue of impairment as a medical issue rather than the issue of disability?

A. Correct.

Q. Can you perhaps describe the kinds of matters you're asked to consult with the agency on?

A. We get a variety of cases in the medical [5] consultant staff beginning, of course, at the state agency level, sometimes progressing through the regional level, and then to the central office, so that one function is to provide a quality review of assessments performed by consultants in the regional offices and in the state agency offices.

We also, of course, get cases from abroad from applicants who have worked in the United States and who have gone abroad and who are applying for disability, foreign claims. That is, we get certain disagreements between state agencies and regional offices and make an attempt to resolve those disagreements, so that we have a variety of cases, and this is the kind of work that I do.

I also do some peer review in the office in terms of assessing work done by my colleagues.

Q. When you say disagreement between state agencies, do you mean over matters of policy or about a particular case?

A. Only medical matters. In my case, psychiatric matters. In terms of severity of a condition.

* * * * *

[42] Q. Well, just let's exclude the mental retardation issue with regard to other kinds of behavioral disturbances such as personality, nonpsychotic disorders. Have you en-

countered those unable to function in structured kinds of settings but, left to their own devices, passably manage?

A. I'm a little confused about the question. Maybe you could put it to me again.

Q. Let me give you an example: A child with a conduct of behavior and disturbance severe enough that [43] he's unable to get along with his peers in the school setting, unable to follow the instructions of the teacher, unwilling to follow the instructions of the teacher. On home bound instruction because he's sufficiently disruptive in a classroom setting, he's limited there, isolated and withdrawn in many respects from his peers in the neighborhood, but who brushes his teeth and takes care of himself more or less, and whose parents, for whatever reason, kind of leave him on his own to set his own schedules, so within that context functions fairly well. Would you visualize that picture I have drawn as being unacceptable or unrealistic or —

A. Well, that situation occurs fairly often. Whether that kind of a situation represents a condition that meets or equals a child listing is another question.

Q. Obviously. Taking the same kind of a situation with an adult, because of a severe personality disorder or something, he is forever telling his boss to take the job and shove it and has difficulty getting along with his spouse and just generalized difficulty getting along with anyone or following instructions, he's been fired a [44] dozen times or quit a dozen times immediately before being fired and had some run-ins with the law here and there because he can't avoid telling the police officer what the police officer should do with himself, but again on his own, sitting around the table and carrying on with friends of like mind and making his own peanut butter and jelly sandwiches or working on the car out in the backyard, does okay. Do you see that as being an unrealistic pattern?

A. Well, again, it's a pattern that occurs pretty often, and the question about whether it meets or equals a listing depends on, you know, many many factors. As a clinician, I would be inclined in assessing someone like like that, I would be inclined to expect more from someone who has a high IQ than from someone who has a low IQ.

Q. Certainly.

A. And I think in terms of making a judgment about severity of impairment, if somebody had an IQ of 60 and was carrying on like that, I might feel that he had in addition a personality disorder substantial enough so [45] that he would meet listing 12.05 C.

Q. For example.

A. And the same with a child.

Q. Absolutely. So you said, if I'm correct, that either this adult or child could well not meet or equal the listed impairment?

A. That's possible, yes.

Q. And yet, as I described it, isn't it difficult to conceive of the adult working?

A. In some cases, yes.

Q. And the—

A. In some cases, yes, but I have to qualify it by saying he still might not meet or equal the listing, even though my gut feeling is that this is a loser and he'll never hold a job.

Q. Some are my clients.

A. But he still might not meet or equal the listing.

Q. A consideration of the extent of his medical limitations, and what remains of the functional capacity, would then take place further down in the sequential [46] evaluation and might lead to the conclusion that he was disabled, in the case of an adult?

A. Yes.

Q. And in the case of a child, if a determination was made that the child did not meet or equal the listed impairment, the child would be of the identical functional symptomatology, that would be the end of the evaluation?

A. True. Let me point out that my feeling about comparing the adult listings, which are then subject to a residual functional capacity assessment, the RFC, with the child listings, for which there is no provision because either the child meets or equals or he does not, and there is no provision for an RFC, that the child listings by and large do specify the kinds of areas that are covered in the RFC in child terms by constantly referring to age appropriate activities and interests and ability to relate to others. So that the items in the RFC which would apply to an adult who would be expected to work, don't correspond one for one with the child listings, but many of them are incorporated * * *

* * * * *

[50] Q. So in the context of children, feeling the way you have about adults, there's even less point in an RFC, but if there was point for either, would that be a correct assessment?

A. Yes, I think so. This is personal opinion, I divorce myself at this point from any policy, but I certainly feel that it has little place in the assessment of children to use that. Now, again, I'm not—I'm bound by the regulations which—

Q. I understand.

A. —really present an either/or situation. Not in my medical assessment. My medical assessment is going to be the same type of rating as for adults, but I know inside that the implications are that if this child does not meet or equal the listings that he will be found not disabled.

Q. Whereas an adult with an identical medical [51] impression could well be found disabled?

A. Yes, but that is not a medical judgment at that point.

MR. KAUFMAN: I don't think I have any further questions.

MR. IMPERATO: Mark, could we recess for a few minutes and see if we have any additional questions?

MR. KAUFMAN: Sure. No problem. I'm sorry, I did have one tiny final question just to tie up the record.

Q. I was given a curriculum vitae of yours. Is that a correct description of your background?

A. That is a correct description of past and current professional activities.

DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE
Social Security Administration

September 7, 1973

SSA DISABILITY INSURANCE LETTER NO III-11

* * * * *

IV. Evaluation of Childhood Disability

A. General

With the implementation of the SSI program, the Social Security Administration will, for the first time, be responsible for evaluating disability in children who are under the age of 18. Moreover, there is no organization known to exist either within or outside the Federal government which has a large scale program involving this type of childhood disability evaluation. (The childhood disability provisions of title II, of course, relate to adults who became disabled prior to the age of 22.)

Evaluation criteria, therefore, will be based on a combination of two factors: (1) experience drawn from the title II disability program insofar as it may relate to children; and (2) expertise provided by medical authorities, particularly by experts in the field of childhood diseases and impairments.

B. Evaluation Considerations

1. *Meaning of Childhood Disability*

Within the context of the basic definition of disability (i.e., an inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental im-

pairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than (twelve months), title XVI provides for a finding of disability in the case of a child under the age of 18 (who is neither married nor the head of a household) if he suffers from any medically determinable physical or mental impairment of "comparable severity."

In considering the application of this provision, it is necessary to define how the ability to function in primary activities appropriate for adults and children may be determined. Historically, the term "disability" has, under title II, been associated exclusively with an inability to work, which is a primary activity of adults. This term, when applied to children, cannot properly be associated with an inability to work, since children are not ordinarily expected to engage in such activity. Accordingly, disability in children must be defined in terms of the primary activity in which they engage, namely growth and development, the process of maturation. Additionally, children even with the same diagnosed disease as an adult, may have different pathophysiologic manifestations of that disease, and the impact of the disease may be quite different. Also, some children will receive traumatic impairments (e.g., the loss of two limbs) which will be the basis for a finding of disability.

These factors make it impossible to compare directly the severity of the child's impairment

with that of an impairment which would prevent an adult from engaging in SGA; thus, in applying the guides, "comparable severity" means that the severity of the impact of the child's impairment(s) must be "comparable" to the severity of the impact of an impairment(s) which would prevent an adult from engaging in any substantial gainful activity. In applying this concept to adjudication, childhood disability will be determined solely in consideration of medical factors. (We are developing additional medical evaluation guides which will provide the detailed findings for use in adjudicating childhood cases.)

2. *Evidence of Childhood Disability*

Medical evidence sufficient to permit an independent determination of disability will be required. Descriptions of a child's activities, behavioral adjustment, and school achievement may be considered in relationship to the overall medical history regarding severity of the impairment.

3. *Vocational Factors*

Vocational factors *will not* be considered in the evaluation of childhood disability. The application of such factors would be inappropriate since the primary activities of children are not generally measured in vocational terms. As previously indicated, work is not a primary activity of children and most individuals in this age category are unemployed. In any event, incidental or casual employment

in which a child might engage would not generally have vocational relevance.

4. *Level of Impairment Severity*

The Listing of Impairments which is used to evaluate title II disability claims solely in consideration of medical factors, will also be utilized to the extent feasible in evaluating title XVI childhood applications.

It is recognized, however, that while some of the existing listings are appropriate for use in evaluating diseases and impairments in children, others are totally inapplicable. Accordingly, guides for determining which of the present title II listings are applicable to children and which are not will be issued separately. In addition, totally new evaluation criteria to be used exclusively with childhood applications are now being developed and will be issued separately.

The guides pertaining to the applicability of the existing title II listings to children, as well as the new childhood evaluation criteria, are to be used to evaluate childhood applications for an interim period of time; during this time our experience with the guides will be carefully analyzed. Permanent evaluation criteria will be formally issued at a later date.

NOTE: The principle of medical equivalence, as outlined in § 404.1505 of the title II regulations, and as detailed in the DIL III-8 Supplement (§ II.E), is fully applicable even though permanent guides have not yet been issued.

5. *Substantial Gainful Activity*

Consonant with overall title XVI disability criteria, any SGA issue which arises with respect to a child will be handled in accordance with the guides provided in § III.E above.

6. *Onset and Cessation Prior to Adjudication*

The criteria for establishing onset and for determining disability which ceased prior to adjudication will be the same for children as for adults under title XVI. (See § III.B.)

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DEPARTMENT OF
HEALTH EDUCATION AND WELFARE
Social Security Administration

January 9, 1974

SSA DISABILITY INSURANCE LETTER NO III-11 -
Supplement 1

(To be filed following DIL III-11 at the end of Part III of
the Disability Insurance State Manual)

Subject: Evaluation of Child Claims Filed Under the
Supplemental Security Income Provisions of
the 1972 Amendments (Public Law 92-603)

* * * * *

I. PURPOSE OF ISSUANCE

This supplement to DIL III-11 discusses general evaluation concepts for child claims under title XVI, the usefulness of the title II "adult" listing is evaluating these claims, and the evaluation of several specific childhood impairments which, as you know, must meet or be equivalent to the severity of the listed impairments to establish disability.

II. BACKGROUND

DIL III-11, Section IV, provides general guides for the evaluation of child claims. As discussed therein, the concept of inability to engage in SGA is not relevant for children under the age of 18. This will undoubtedly require development of suitable supplements to existing criteria in the Listing of Impairments. The uniqueness of the provisions applicable to children and the absence of any existing child programs from which appropriate criteria can be adopted will necessitate considerable experience in adjudication before criteria can be established.

Section 1614(a)(3)(A) of the Social Security Act, as provided by § 301 of Public Law 92-603, permits payment of benefits to "a child under age 18, if he suffers from any medically determinable physical or mental impairment of comparable severity" to that which shall be considered disabling for an adult. Subpart I of Regulations No. 16 (as currently proposed) specifically requires that a child's impairment or impairments must either *meet* or *equal* the listing of impairments which will be published in an appendix to that subpart. (That listing is practically identical to the listing used in the title II program, the appendix to subpart P of Regulations No. 4.) It is expected that some claims will involve childhood diseases or manifestations of disease, which are not adequately described by the appendix and which, therefore, do not "meet" the requirements of the appendix listing. Until a separate listing can be included in the Regulations of childhood impairments "of comparable severity" to adult impairments, it will be necessary to apply standards described in this supplement and future supplements in evaluating claims where the child's impairment may "equal" rather than "meet" the current adult listing.

This supplement is designed, therefore, to be used by the SA in determining whether or not the severity of the child's impairment is medically the equivalent to a currently listed impairment. Later, as experience is gained and supplemental criteria for evaluating child claims are developed, they will be published in the regulations.

III. THE CONCEPT OF COMPARABLE SEVERITY

The provisions applicable to children will require not only the development of additional, more specific criteria, but also a definition of the phrase "impairment of comparable severity." It is evident that an impairment of com-

parable severity in a child cannot be judged on the same basis as an impairment which prevents an adult from engaging in substantial gainful activity, since children are not expected to so engage. Moreover, children should not be considered as "little adults." Children, even with the same diagnosed disease as an adult, may have different pathophysiologic manifestations of that disease and the impact on the child of impairment from the disease may be different. Children may be said to engage in the process of growth and development, this is, the process of maturation. Specifically, this involves (1) growth— increase in size and maturation of physical and functional characteristics, (2) learning, (3) mastering basic skills, and (4) emotional and social development. In defining "comparable severity," therefore, we attempt to describe childhood impairments which interfere with maturation to the same extent as the adult medical criteria describe adult impairments which prevent substantial gainful activity. The factors to be compared are the *impact* of the child's impairment on the child's life and the impact of the adult's impairment on the adult's life.

IV. EVALUATING CHILD CLAIMS

The medical criteria (Listing of Impairments) in the Appendix to Subpart P, Regulations No. 4, (virtually the same as the listing in the appendix to proposed Subpart I of Regulations No. 16), have been reviewed to assess their usefulness for evaluation of childhood impairments. A section of this material provides a tabulation of the listing subsections, with a comment on such usefulness. (See *Exhibit 1*.) Also provided as part of this material (see *Exhibit 2*) are childhood impairment guides; this list will be expanded in the future as experience dictates. These materials have evolved from discussion based on program

experience in dealing with claims involving adult impairments. They are intended primarily to provide guidance in determining whether or not a child's impairment is equivalent in severity to a listed impairment. Exhibit 2 describes impairments, the impact of which will interfere with the child's major activities (i.e., growth and development) to the same extent as the impact of the impairments listed in the adult criteria interfere with the adult's ability to engage in substantial gainful activity.

V. MEDICAL EQUIVALENCY CONCEPT

Case adjudication, particularly until the medical guides for evaluating child claims are adequately refined, will depend heavily on the proper use of a "medical equivalency" concept which takes into account the particular effect of disease processes in childhood. In addition to the need for adjudicating under the "equals" concept where none of the adult listings can be applied, consideration must be given to the combined effect of multiple impairments, each of which, singly, is short of the listings. Exhibit 2 lists such combinations of impairments that are frequently seen together (e.g., C111.02, C111.07) without specifying a severity level for the individual impairments. Each impairment must have some substantial adverse effect on the child's major daily activities, and together must "equal" the specified impact. It must be understood that each impairment to be so considered in the combination would, of necessity, not "meet" or "equal" the requirements alone, but must represent more than a slight or mild impairment.

VI. ADVERSE FACTORS OF LEARNING AND BEHAVIOR

Not all children's impairments will lend themselves to formal codification. We are aware that a significant number of children are impaired in their intellectual, social,

and emotional developmental progression by problems of learning and/or behavior. These conditions may be ill-defined and imperfectly understood. Diagnostic criteria are not universally agreed upon. They include such phenomena as perceptual handicaps, dyslexia, hyperactivity, minimal cerebral dysfunction, distractability, poor self-concept, emotional lability, etc. At the present time, specific anatomic, physiologic, or psychologic abnormalities are not unequivocally demonstrable by medically acceptable clinical and laboratory diagnostic techniques. They are not severe enough to cause the requisite level of impairment severity in and of themselves, but may act as adverse factors when another medically determinable impairment exists. Medical, psychological, and/or educational diagnostic techniques that have been performed on these children should, therefore, be requested, along with references delineating standardization and validity of less widely known procedures. In this way, traditionally medically determinable impairments complicated by problems of learning and/or behavior may be more effectively adjudicated.

VII. DEVELOPMENTAL MILESTONES

A compilation of data on "developmental milestones" is being prepared which indicates the ages at which the average healthy child generally acquires new skills and proficiencies in the areas of social, intellectual, and physical development. This information is designed primarily for assessment of impairments involving abnormal or retarded growth and development occurring either as a primary impairment or secondary to another physical or mental impairment. Medical evaluation discussion is based upon evidence which adequately describes the child's growth and development. In the near future, it is

expected that in specified cases a short questionnaire on the most evident of the growth and development factors will be completed in the district office. This information will be useful for screening certain types of applicants and for deciding whether additional evidence is necessary, but the questionnaire alone will not provide sufficient probative evidence for impairment assessment.

VIII. SCHOOL ATTENDANCE

Attendance at school, even if full-time or in the proper grade, should not be considered to rule out the presence of a severe impairment. Conversely, absence from school or poor performance at school does not represent a factor which can be used to properly determine the presence of an impairment. It is necessary to evaluate the impairment which interferes with these events.

IX. QUESTIONS AND COMMENTS REQUESTED

It is important that State agencies provide comments concerning the usefulness of this issuance and the published criteria in adjudicating childhood claims. These comments may be made in a number of ways, as best suits the procedure in the State agency, but should include: (1) statements made directly on cases which should be sent to BDI after adjudication and any necessary post adjudication review (e.g., in the Claims Review Section) are completed, pointing out problems concerning utility of the issuance or of the published criteria for expeditious adjudication, and (2) a more general discussion of this issuance which should be sent to BDI at any time the need arises.

In both instances, send comments to the BDI Central Office, to the attention of Herbert L. Blumenfeld, M.D., Room 2300 Dickinson Building.

Bernard Popick, Director
Bureau of Disability Insurance

Attachments: Exhibits 1 and 2

January 9, 1974

Exhibit 1

Usefulness of "Adult" Listing of Impairments

(Appendix to Subpart P, Regulations No. 4) to Child Claims

- I. Childhood Impairment Guides
 - A. Discussion of these childhood impairments is being furnished at the present time:
 - Section C 100.00 – Growth.
 - Sections C 102.00G, C 102.08 – Hearing impairments.
 - Section C 107.05 – Sickle cell anemia.
 - Section C 107.11 – Acute leukemia.
 - Section C 109.08 – Juvenile diabetes mellitus.
 - Section C 110.08 – Multisystemic catastrophic disease.
 - Sections C 111.00A, C 111.02 – Convulsive seizures.
 - Section C 111.00C, C 111.07 – Cerebral palsy.
 - Section C 112.00 ff – Mental and emotional disorders.
 - Malignant neoplasms:
 - Section C 113.14 – Anterior Mediastinum.
 - Section C 113.19 – Liver.
 - Section C 113.24 – Testicles.
 - Section C 113.26 – Ovaries.
 - Section C 113.28 – Neuroblastoma.
 - Section C 113.29 – Wilms' tumor.
 - Section C 113.30 – Sacrococcygeal tumors.
 - Section C 113.31 – Teratocarcinoma or Choriocarcinoma.
 - Section C 113.32 – Retinoblastoma.

- B. These additional new guides will be furnished in the near future:

Cystic fibrosis.
 Congenital heart disease.
 Endocrine disorders.
 Renal disorders.

- II. These published listings will be useful as written:

Sections 1.05A, 1.06, 1.09, 1.10, 1.11, 1.12.
 Sections 2.02, 2.03A, 2.03B, 2.05, 2.06.
 Sections 3.08B, 3.08C, 3.10.
 Section 4.05.
 Sections 5.04A, 5.04B, 5.04C, 5.05A, 5.05C,
 5.05D, 5.06A, 5.06B, 5.06C, 5.07A,
 5.07B.
 Sections 6.02A, 6.04, 6.05.
 Sections 7.07, 7.08, 7.10B, 7.13.
 Section 8.00 ff.
 Sections 9.08A, 9.08B1.
 Section 10.00 ff.
 Sections 11.04, 11.05, 11.08 to 11.14.
 Section 13.00 ff, except 13.19, 13.24, 13.26.

- III. Disease seen in children, but level of severity or criteria description will need to be changed:

Sections 1.02, 1.04, 1.05C, 1.08
 Sections 2.03C, 2.04, 2.08*.
 Sections 3.07, 3.08A, 3.11.
 Sections 4.02, 4.09, 4.10.
 Sections 5.03, 5.04D, 5.05B, 5.06D, 5.07C, 5.08.
 Sections 6.02B, 6.03.
 Sections 7.02 to 7.04, 7.05*, 7.06, 7.09, 7.10A,
 7.10C, 7.10D, 7.11*, 7.12, 7.14.
 Sections 9.02 to 9.07, 9.08B2*.
 Sections 11.02*, 11.03*, 11.07*, 11.17*.

Section 12.00 ff*.

Sections 13.19*, 13.24*, 13.26*.

(*Refer to new listing)

- IV. Generally not seen in young children:

Sections 1.03, 1.05B, 1.07.

Section 2.07.

Sections 3.02 to 3.06, 3.08D, 3.09.

Sections 4.03, 4.04, 4.06 to 4.08, 4.11 to 4.13.

Section 5.02.

Sections 9.08B3, 9.08B4.

Sections 11.06, 11.15, 11.16.

Exhibit 2

Childhood Impairment Guides

C 100.00 — *Growth Impairments*

C 100.00A — Determinations of growth impairment should be based on the comparison of current height with at least three previous determinations, including length at birth, if available. Heights (or lengths) should be plotted on the Standard Growth Chart prepared by the Harvard School of Public Health; this should be included in the folder. Height should be measured without shoes. Body weight corresponding to the ages represented by the heights should be furnished, if available. The adult heights of the child's natural parents and the height and age of siblings should also be furnished, if available, to provide a basis upon which to identify those children whose short stature represents a family characteristic rather than a result of disease.

Bone age determinations should include a full descriptive report, and must cite the standardization method used. Where roentgenograms have not previously been obtained to determine bone age in a child otherwise displaying apparent growth retardation, they must be obtained currently as a basis for adjudication under the following criteria. Where bone roentgenograms are obtained by the Administration, views of the left hand and wrist should be ordered. Additional roentgenograms of the knee and ankle should

be obtained when cessation of growth is being evaluated. The result of such roentgenograms should always be made available to the treating physician. The requirement of bone age retardation is not applicable to individuals with growth impairment resulting from malabsorption; growth impairment in these individuals should be considered under the criteria in Section C 100.02B and C. The criteria in this section are applicable only until closure of the major epiphyses.

C 100.01 — *Category of Impairments, Growth*

C 100.02 Growth impairment, as evidenced by bone age greater than one standard deviation (1 SD) below the mean for chronological age, and one of the following:

- A. Continuing or sustained fall of greater than 25 percentiles in height; or
- B. Continuing or sustained fall of greater than 15 percentiles in height *and* an additional medically determined impairment; or
- C. Fall to, or persistence of, height below the third percentile *and* an additional medically determined impairment.

C 102.00 — *Special Sense Organs*

C 102.00D *Deafness.* The criteria for hearing loss in children take into account that a smaller loss occurring at an early age, which is not correctable by definitive short-term therapy, may result in a severe speech defect. The criteria in Section 102.08 describe conditions most applicable in the younger age group,

and should be used in children through 12 years of age. Above the age of 12 years, the criteria in Section 2.08 should be applied.

Improvement by a hearing aid, as predicted by the testing procedure, must be demonstrated to be feasible in that child, since younger children may be unable to use a hearing aid effectively.

The type of testing performed should be described. A copy of the graphic representation of audiometric testing should be included in the report. If a standard audiometer is used, as will usually be the case, the report should indicate whether the apparatus was calibrated according to American National Standard Institute Specifications for Audiometers, S 3.6-1969 (ANSI-1969) or American Standard, Z 24.5-1951 (ASA-1951). The decibel levels cited in Section C 102.08 are based on use of the ANSI-1969 calibration. Testing should be done at the three frequencies of 500, 1000 and 2000 Hertz (Hz). Auditory perception of better than the level required in Section 102.08 at only a single tonal frequency between 500 and 2000 Hz will be considered as meeting the requirements of the criteria.

C 102.08 *Hearing Impairments*

- A. For children whose claims are adjudicated below age 5 years, absence of bilateral auditory perception at greater than 40 decibels; or

- B. For children whose claims are adjudicated from 5 years of age and above:

1. Absence of bilateral auditory perception at greater than 80 decibels, not correctable by a hearing aid; or
2. Absence of bilateral auditory perception at greater than 40 decibels, not correctable by a hearing aid *and* speech deficit involving clarity and content, attributable to the hearing loss.

C 107.00 *Hemic and Lymphatic System*

C 107.00B — *Leukemia*: The criteria in Section C 107.11 take into account the implications and consequences to the child attendant upon this diagnosis, as well as the recent great strides in treatment, which an increasing number of prolonged, sustained remissions.

C 107.05 — *Sickle Cell Anemia*: With hematocrit of 25 percent or less; and

- A. Growth retardation as in Section C 100.00; or
- B. Documented recurrent, severe, painful (thrombotic) crises; or
- C. Recurrent major lower respiratory infections requiring hospitalization; or
- D. A major complication (such as hyperhemolytic or aplastic crisis, renal or cardiac failure, severe meningitis, or osteomyelitis) within six months preceding adjudication.

C 107.11 *—Acute Leukemia:*

- A. Consider under severe impairment for one year after complete remission; or
- B. With relapse or recurrence.

C 109.08 *Juvenile Diabetes Mellitus*

- A. *Juvenile diabetes mellitus* manifested by significant ketonemia or lowering of plasma bicarbonate or pH requiring hospital care on the average of at least once every two months.
- B. *Juvenile diabetes mellitus* with growth retardation (such as in Moriak syndrome or with malabsorption or renal disease).
- C. When juvenile diabetes mellitus exists or results in other physical or mental impairments, consider in conjunction with the criteria for the appropriate body system.

C 110.00 *Multiple Body System*C 110.08 *Catastrophic Congenital Abnormalities or Disease*

- A. With a positive diagnosis (such as anencephaly, trisomy D or E, cyclopsia, etc.), generally regarded as being incompatible with extra-uterine life; or
- B. With a positive diagnosis (such as cri du chat, Tay-Sachs, maple syrup urine disease, etc.), wherein attainment of the growth and development level of two years is not expected to occur.

C 111.00 *Neurological*

C 111.00A *Convulsive Seizures:* The documentation of epilepsy in childhood is subject to the same requirement stated in Section 11.00A. Criteria have been provided in Section C 111.02 for infantile myoclonic seizures and for major convulsive seizures in combination with other impairments. Specific criteria for adjudication of cases involving only major convulsive seizures in children are not being furnished at the present time. Seizures in children may differ from those in adults in terms of pattern, duration, and manifestations of the post-ictal phase and response to therapy. The impact on the child's life may be different. The criteria in Section 11.02 or 11.03 are not felt to describe impairments which significantly interfere with growth or development in a child or which constitute an "impairment of comparable severity" as required in Section 1614(a)(3)(A) of Public Law 92-603. Adjudication of childhood claims based on major convulsive seizures, unaccompanied by another significant impairment should take into account the impact on the child of seizure episodes, duration of the post-ictal phase, and other residua, and the extent to which these interfere with major daily activities for age or progression of development.

C 111.00C *Cerebral Palsy:* Documentation of cerebral palsy should include results of an examination describing the area of neuromuscular involvement, the appearance, any contractures or deformities, and the degree of spasticity, weakness, tremor, ataxia, or athetosis.

The requirement of significant interference with the stated functions in Section C 111.07A should be interpreted as requiring a level of involvement on a neuro-musculo-skeletal basis alone which will interfere with the child's major daily activities for age and with progression of development. The criteria in Sections C 111.07C through F are based on the combined effect of two or more impairments, each of which is short of the requirements listed for a single impairment, but is greater than of slight or mild severity.

- C 111.02 *Major Convulsive Seizures:* Occurring in spite of prescribed therapy.
- A. See Section C 111.00A; or
 - B. In combination with:
 - 1. I.Q. below 70; or
 - 2. Cerebral palsy; or
 - 3. Emotional disorder; or
 - 4. Impaired vision, hearing, or speech; or
 - C. Infantile myoclonic seizures with characteristic EEG pattern of hypsarrhythmia.
- C 111.07 *Cerebral Palsy:* With persistent spasticity, weakness, tremor, ataxia, or athetosis involving two extremities; and
- A. Significant interference with gross and fine movements or locomotion and station for age; or
 - B. Positive diagnosis of cerebral palsy made before one year of age; or
 - C. I.Q. below 70; or
 - D. Convulsive seizures; or

- E. Impaired vision, hearing, or speech; or
- F. Mental or emotional disorder.

C 112.00

Mental and Emotional Disorders

This section is primarily intended to describe mental and emotional disorders of young children. The medical criteria describing impairments in adults should be used when they clearly appear to be more appropriate.

Mental retardation (C 112.05) should be determined on the basis of medical reports, I.Q. measurements, and developmental milestone criteria. Standardized tests such as the Wechsler Preschool and Primary Scale of Intelligence (WPPSI), the Wechsler Intelligence Scale for Children (WISC), the Binet, and the Bayley Scale should be used whenever possible. Key data such as subtest scores should be included in the report.

Developmental milestone criteria (such as appear in standard pediatric texts and the February 1973 *Pediatric Clinics of North America*) should be included. When the age and condition of the child preclude the standardized tests described above, developmental criteria, based upon a physician's evaluation, may be the basis for adjudication.

Other widely used pediatric screening devices (such as the Denver Developmental, the "Draw-A-Person", and the Peabody Picture Vocabulary Test) should be included whenever this information is available.

C 112.02

Chronic Brain Syndrome with arrest of developmental progression for six months or loss of previously acquired abilities.

- C 112.03 *Psychosis of Infancy and Childhood* manifested by impaired relationships with others, impaired sense of reality, and one of the following:
- A. Significant withdrawal or detachment, or
 - B. Bizarre behavior patterns, or
 - C. Strong need for maintenance of sameness, with intense anxiety, fear, and anger when change is introduced, or
 - D. Panic at threat of separation from parent.
- C 112.04 *Functional Non-Psychotic Disorders* with symptom formation which renders the child unable to perform major daily age-appropriate activities, and one of the following:
- A. Psychophysiologic disorder.
 - B. Marked anxiety.
 - C. Weight loss with malnutrition (see Section C 100.00 ff).
 - D. Persistent inappropriate behavior (i.e., excessive pre-occupation, withdrawal, or compulsive-ritualistic behavior).
- C 112.05 *Mental Retardation*
- A. Achievement of only those developmental milestones generally acquired by children up to one-half the child's chronologic age, or
 - B. I.Q. of 59 or less, or
 - C. I.Q. of 60-69, inclusive, with marked dependence, for age, upon others for basic personal needs (i.e., feeding,

washing) and a physical or other mental impairment resulting in restriction of function and developmental progression.

- C 113.00 *Neoplastic Diseases—Malignant*
- C 113.14 *Anterior Mediastinum*
- A. Teratoma with recurrence; or
 - B. Malignant thymoma with recurrence; or
 - C. Ganglioneuroma with malignant change or recurrence.
- C 113.19 *Liver*
- A. Hepatoblastoma, argentaffinoma, or hepatic or biliary cell carcinoma; or
 - B. Metastatic malignant tumors to liver.
- C 113.24 *Testicles*
- A. Teratocarcinoma, choriocarcinoma, or embryonal cell carcinoma; or
 - B. Seminoma not controlled by prescribed therapy.
- C 113.26 *Ovaries*
- A. Teratocarcinoma, choriocarcinoma, or adenocarcinoma; or
 - B. Granulosa or thecal cell tumors, or arrhenoblastoma, with
 1. Metastases; or
 2. Recurrence.
- C 113.28 *Neuroblastoma*
- A. Onset at 24 months of age or later; or
 - B. Bone or marrow involvement; or
 - C. Not controlled by definitive therapy; or
 - D. Recurrent after definitive therapy.

- C 113.29 *Wilms' Tumors*
 A. Not controlled by prescribed therapy; or
 B. Recurrent.
- C 113.30 *Sacroccygeal Tumors*
 A. Malignant, or
 B. Histologically benign tumors recurrent after radical surgery.
- C 113.31 *Teratocarcinoma or Choriocarcinoma*: Occuring in any location except anterior mediastinum (See Section C 113.14A).
- C 113.32 *Retinoblastoma*
 A. Bilateral involvement; or
 B. Metastatic or extending beyond the orbit; or
 C. Recurrent.

LISTING OF IMPAIRMENTS
20 C.F.R. Part 404, Subpart P, Appendix 1 (1988)

In the Listing of Impairments, the listings under each separate body system in both Part A and Part B will be effective for periods ranging from 4 to 8 years unless extended or revised and promulgated again. Specifically, the body system listings in the Listing of Impairments will be subject to the following termination dates:

Musculoskeletal system (1.00) within 5 years. Consequently, the listings in this body system will no longer be effective on December 6, 1990.

Respiratory system (3.00) within 6 years. Consequently, the listings in this body system will no longer be effective on December 6, 1991.

Cardiovascular system (4.00) within 4 years. Consequently, the listings in this body system will no longer be effective on December 6, 1989.

The listings under the other body systems in Part A and Part B will expire in 8 years. Consequently, the listing in these body systems will no longer be effective on December 6, 1993. The mental disorders listings in Part A will expire on August 27, 1988, unless extended or revised and promulgated again.

Part A

Criteria applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.

Sec.

- 1.00 Musculoskeletal System.
- 2.00 Special Senses and Speech.
- 3.00 Respiratory System.
- 4.00 Cardiovascular System.
- 5.00 Digestive System.
- 6.00 Genito-Urinary System.

- 7.00 Hemic and Lymphatic System.
- 8.00 Skin.
- 9.00 Endocrine System.
- 10.00 Multiple Body Systems.
- 11.00 Neurological.
- 12.00 Mental Disorders.
- 13.00 Neoplastic Diseases, Malignant.

1.00 MUSCULOSKELETAL SYSTEM

A. *Loss of function* may be due to amputation or deformity. Pain may be an important factor in causing functional loss, but it must be associated with relevant abnormal signs or laboratory findings. Evaluations of musculoskeletal impairments should be supported where applicable by detailed descriptions of the joints, including ranges of motion, condition of the musculature, sensory or reflex changes, circulatory deficits, and X-ray abnormalities.

B. *Disorders of the spine*, associated with verte-brogenic disorders as in 1.05C, result in impairment because of distortion of the bony and ligamentous architecture of the spine or impingement of a herniated nucleus pulposus or bulging annulus on a nerve root. Impairment caused by such abnormalities usually improves with time or responds to treatment. Appropriate abnormal physical findings must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that severe impairment will last for a continuous period of 12 months. This may occur in cases with unsuccessful prior surgical treatment.

Evaluation of the impairment caused by disorders of the spine requires that a clinical diagnosis of the entity to be evaluated first must be established on the basis of adequate history, physical examination, and roentgenograms.

The specific findings stated in 1.05C represent the level required for that impairment; these findings, by themselves, are not intended to represent the basis for establishing the clinical diagnosis. Furthermore, while neurological examination findings are required, they are not to be interpreted as a basis for evaluating the magnitude of any neurological impairment. Neurological impairments are to be evaluated under 11.00-11.19.

The history must include a detailed description of the character, location, and radiation of pain; mechanical factors which incite and relieve pain; prescribed treatment, including type, dose, and frequency of analgesic; and typical daily activities. Care must be taken to ascertain that the reported examination findings are consistent with the individual's daily activities.

There must be a detailed description of the orthopedic and neurologic examination findings. The findings should include a description of gait, limitation of movement of the spine given quantitatively in degrees from the vertical position, motor and sensory abnormalities, muscle spasm, and deep tendon reflexes. Observations of the individual during the examination should be reported; e.g., how he or she gets on and off the examining table. Inability to walk on heels or toes, to squat, or to arise from a squatting position, where appropriate, may be considered evidence of significant motor loss. However, a report of atrophy is not acceptable as evidence of significant motor loss without circumferential measurements of both thighs and lower legs (or upper or lower arms) at a stated point above and below the knee or elbow given in inches or centimeters. A specific description of atrophy of hand muscles is acceptable without measurements of atrophy but should include measurements of grip strength.

These physical examination findings must be determined on the basis of objective observations during the

examination and not simply a report of the individual's allegation, e.g., he says his leg is weak, numb, etc. Alternative testing methods should be used to verify the objectivity of the abnormal findings, e.g., a seated straight-leg raising test in addition to a supine straight-leg raising test. Since abnormal findings may be intermittent, their continuous presence over a period of time must be established by a record of ongoing treatment. Neurological abnormalities may not completely subside after surgical or nonsurgical treatment, or with the passage of time. Residual neurological abnormalities, which persist after it has been determined clinically or by direct surgical or other observation that the ongoing or progressive condition is no longer present, cannot be considered to satisfy the required findings in 1.05C.

Where surgical procedures have been performed, documentation should include a copy of the operative note and available pathology reports.

Electrodiagnostic procedures and myelography may be useful in establishing the clinical diagnosis, but do not constitute alternative criteria to the requirements in 1.05C.

C. *After maximum benefit from surgical therapy* has been achieved in situations involving fractures of an upper extremity (see 1.12) or soft tissue injuries of a lower or upper extremity (see 1.13), i.e., there have been no significant changes in physical findings or X-ray findings for any 6-month period after the last definitive surgical procedure, evaluation should be made on the basis of demonstrable residuals.

D. *Major joints* as used herein refer to hip, knee, ankle, shoulder, elbow, or wrist and hand. (Wrist and hand are considered together as one major joint.)

E. *The measurements of joint motion* are based on the techniques described in the "Joint Motion Method of Measuring and Recording," published by the American Academy of Orthopedic Surgeons in 1965, or the "Guides

to the Evaluation of Permanent Impairment—The Extremities and Back" (Chapter I); American Medical Association, 1971.

1.01 Category of Impairments, Musculoskeletal

1.02 *Active rheumatoid arthritis and other inflammatory arthritis.*

With both A and B.

A. History of persistent joint pain, swelling, and tenderness involving multiple major joints (see 1.00D) and with signs of joint inflammation (swelling and tenderness) on current physical examination despite prescribed therapy for at least 3 months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last at least 12 months; and

B. Corroboration of diagnosis at some point in time by either.

1. Positive serologic test for rheumatoid factor; or
2. Antinuclear antibodies; or
3. Elevated sedimentation rate; or
4. Characteristic histologic changes in biopsy of synovia membrane or subcutaneous nodule (obtained independent of Social Security disability evaluation).

1.03 *Arthritis of a major weight-bearing joint (due to any cause):*

With history of persistent joint pain and stiffness with signs of marked limitation of motion or abnormal motion of the affected joint on current physical examination. With:

A. Gross anatomical deformity of hip or knee (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) supported by X-ray evidence of either significant joint space narrowing or significant bony destruction and markedly limiting ability to walk and stand; or

B. Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint and return to full weight-bearing.

ing status did not occur, or is not expected to occur, within 12 months of onset.

1.04 Arthritis of one major joint in each of the upper extremities (due to any cause):

With history of persistent joint pain and stiffness, signs of marked limitation of motion of the affected joints on current physical examination, and X-ray evidence of either significant joint space narrowing or significant bony destruction. With:

A. Abduction and forward flexion (elevation) of both arms at the shoulders, including scapular motion, restricted to less than 90 degrees; or

B. Gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability, ulnar deviation) and enlargement or effusion of the affected joints.

1.05 Disorders of the spine:

A. Arthritis manifested by ankylosis or fixation of the cervical or dorsolumbar spine at 30° or more of flexion measured from the neutral position, with X-ray evidence of:

1. Calcification of the anterior and lateral ligaments; or

2. Bilateral ankylosis of the sacroiliac joints with abnormal apophyseal articulations; or

B. Osteoporosis, generalized (established by X-ray) manifested by pain and limitation of back motion and paravertebral muscle spasm with X-ray evidence of either:

1. Compression fracture of a vertebral body with loss of at least 50 percent of the estimated height of the vertebral body prior to the compression fracture, with no intervening direct traumatic episode; or

2. Multiple fractures of vertebrae with no intervening direct traumatic episode; or

C. Other vertebrogenic disorders (e.g., herniated nucleus pulposus, spinal stenosis) with the following persisting for at least 3 months despite prescribed therapy and expected to last 12 months. With both 1 and 2:

1. Pain, muscle spasm, and significant limitation of motion in the spine; and

2. Appropriate radicular distribution of significant motor loss with muscle weakness and sensory and reflex loss.

1.08 Osteomyelitis or septic arthritis (established by X-ray):

A. Located in the pelvis, vertebra, femur, tibia, or a major joint of an upper or lower extremity, with persistent activity or occurrence of at least two episodes of acute activity within a 5-month period prior to adjudication, manifested by local inflammatory, and systemic signs and laboratory findings (e.g., heat, redness, swelling, leucocytosis, or increased sedimentation rate) and expected to last at least 12 months despite prescribed therapy; or

B. Multiple localizations and systemic manifestations as in A above.

1.09 Amputation or anatomical deformity of (i.e., loss of major function due to degenerative changes associated with vascular or neurological deficits, traumatic loss of muscle mass or tendons and X-ray evidence of bony ankylosis at an unfavorable angle, joint subluxation or instability):

A. Both hands; or

B. Both feet; or

C. One hand and one foot.

1.10 Amputation of one lower extremity (at or above the tarsal region):

A. Hemipelvectomy or hip disarticulation; or

B. Amputation at or above the tarsal region due to peripheral vascular disease or diabetes mellitus; or

C. Inability to use a prosthesis effectively, without obligatory assistive devices, due to one of the following:

1. Vascular disease; or
2. Neurological complications (e.g., loss of position sense); or
3. Stump too short or stump complications persistent, or are expected to persist, for at least 12 months from onset; or
4. Disorder of contralateral lower extremity which markedly limits ability to walk and stand.

1.11 *Fracture of the femur, tibia, tarsal bone of pelvis* with solid union not evident on X-ray and not clinically solid, when such determination is feasible, and return to full weight-bearing status did not occur or is not expected to occur within 12 months of onset.

1.12 *Fractures of an upper extremity* with non-union of a fracture of the shaft of the humerus, radius, or ulna under continuing surgical management directed toward restoration of functional use of the extremity and such function was not restored or expected to be restored within 12 months after onset.

1.13 *Soft tissue injuries of an upper or lower extremity* requiring a series of staged surgical procedures within 12 months after onset for salvage and/or restoration of major function of the extremity, and such major function was not restored or expected to be restored within 12 months after onset.

2.00 SPECIAL SENSES AND SPEECH

A. Ophthalmology

1. *Causes of impairment.* Diseases or injury of the eyes may produce loss of central or peripheral vision. Loss of central vision results in inability to distinguish detail and prevents reading and fine work. Loss of peripheral

vision restricts the ability of an individual to move about freely. The extent of impairment of sight should be determined by visual testing.

2. *Central visual acuity.* A loss of central visual acuity may be caused by impaired distant and/or near vision. However, for an individual to meet the level of severity described in 2.02 and 2.04, only the remaining central visual acuity for distance of the better eye with best correction based on the Snellen test chart measurement may be used. Correction obtained by special visual aids (e.g., contact lenses) will be considered if the individual has the ability to wear such aids.

3. *Field of vision.* Impairment of peripheral vision may result if there is contraction of the visual fields. The contraction may be either symmetrical or irregular. The extent of the remaining peripheral visual field will be determined by usual perimetric methods at a distance of 330 mm. under illumination of not less than 7-foot candles. For the phakic eye (the eye with a lense), a 3 mm. white disc target will be used, and for the aphakic eye (the eye without the lens), a 6 mm. white disc target will be used. In neither instance should corrective spectacle lenses be worn during the examination but if they have been used, this fact must be stated.

Measurements obtained on comparable perimetric devices may be used; this does not include the use of tangent screen measurements. For measurements obtained using the Goldmann perimeter, the object size designation III and the illumination designation 4 should be used for the phakic eye, and the object size designation IV and illumination designation 4 for the aphakic eye.

Field measurements must be accompanied by notated field charges, a description of the type and size of the target and the test distance. Tangent screen visual fields are not acceptable as a measurement of peripheral field loss.

Where the loss is predominantly in the lower visual fields, a system such as the weighted grid scale for perimetric fields described by B. Esterman (see Grid for Scoring Visual Fields, II. Perimeter, *Archives of Ophthalmology*, 79:400, 1968) may be used for determining whether the visual field loss is comparable to that described in Table 2.

4. *Muscle function.* Paralysis of the third cranial nerve producing ptosis, paralysis of accommodation, and dilation and immobility of the pupil may cause significant visual impairment. When all the muscle of the eye are paralyzed including the iris and ciliary body (total ophthalmoplegia), the condition is considered a severe impairment provided it is bilateral. A finding of severe impairment based primarily on impaired muscle function must be supported by a report of an actual measurement of ocular motility.

5. *Visual efficiency.* Loss of visual efficiency may be caused by disease or injury resulting in a reduction of central visual acuity or visual field. The visual efficiency of one eye is the product of the percentage of central visual efficiency and the percentage of visual field efficiency. (See Tables No. 1 and 2, following 2.09.)

6. *Special situations.* Aphakia represents a visual handicap in addition to the loss of central visual acuity. The term monocular aphakia would apply to an individual who has had the lens removed from one eye, and who still retains the lens in his other eye, or to an individual who has only one eye which is aphakic. The term binocular aphakia would apply to an individual who has had both lenses removed. In cases of binocular aphakia, the central efficiency of the better eye will be accepted as 75 percent of its value. In cases of monocular aphakia, where the better eye is aphakic, the central visual efficiency will be accepted as 50 percent of the value. (If an individual has

binocular aphakia, and the central visual acuity in the poorer eye can be corrected only to 20/200, or less, the central visual efficiency of the better eye will be accepted as 50 percent of its value.)

Ocular symptoms of systemic disease may or may not produce a disabling visual impairment. These manifestations should be evaluated as part of the underlying disease entity by reference to the particular body system involved.

7. *Statutory blindness.* The term "statutory blindness" refers to the degree of visual impairment which defines the term "blindness" in the Social Security Act. Both 2.02 and 2.03 A and B denote statutory blindness.

B. *Otolaryngology*

1. *Hearing impairment.* Hearing ability should be evaluated in terms of the person's ability to hear and distinguish speech.

Loss of hearing can be quantitatively determined by an audiometer which meets the standards of the American National Standards Institute (ANSI) for air and bone conducted stimuli (i.e., ANSI S 3.6-1969 and ANSI S 3.13-1972, or subsequent comparable revisions) and performing all hearing measurements in an environment which meets the ANSI standard for maximal permissible background sound (ANSI S 3.1-1977).

Speech discrimination should be determined using a standardized measure of speech discrimination ability in quiet at a test presentation level sufficient to ascertain maximum discrimination ability. The speech discrimination measure (test) used, and the level at which testing was done, must be reported.

Hearing tests should be preceded by an otolaryngologic examination and should be performed by or under the supervision of an otolaryngologist or audiologist qualified to perform such tests.

In order to establish an independent medical judgment as to the level of impairment in a claimant alleging deafness, the following examinations should be reported: Otolaryngologic examination, pure tone air and bone audiometry, speech reception threshold (SRT), and speech discrimination testing. A copy of reports of medical examination and audiologic evaluations must be submitted.

Cases of alleged "deaf mutism" should be documented by a hearing evaluation. Records obtained from a speech and hearing rehabilitation center or a special school for the deaf may be acceptable, but if these reports are not available, or are found to be inadequate, a current hearing evaluation should be submitted as outlined in the preceding paragraph.

2. *Vertigo associated with disturbances of labyrinthine-vestibular function, including Meniere's disease.* These disturbances of balance are characterized by an hallucination of motion or loss of position sense and a sensation of dizziness which may be constant or may occur in paroxysmal attacks. Nausea, vomiting, ataxia, and incapacitation are frequently observed, particularly during the acute attack. It is important to differentiate the report of rotary vertigo from that of "dizziness" which is described as light-headedness, unsteadiness, confusion, or syncope.

Meniere's disease is characterized by paroxysmal attacks of vertigo, tinnitus, and fluctuating hearing loss. Remissions are unpredictable and irregular, but may be long-lasting; hence, the severity of impairment is best determined after prolonged observation and serial reexaminations.

The diagnosis of a vestibular disorder requires a comprehensive neuro-otolaryngologic examination with a detailed description of the vertiginous episodes, including notation of frequency, severity, and duration of the attacks. Pure tone and speech audiometry with the appro-

priate special examinations, such as Bekesy audiometry, are necessary. Vestibular functions is assessed by positional and caloric testing, preferably by electronystagmography. When polytograms, contrast radiography, or other special tests have been performed, copies of the reports of these tests should be obtained in addition to reports of skull and temporal bone X-rays.

3. *Organic loss of speech.* Glossectomy or laryngectomy or cicatricial laryngeal stenosis due to injury or infection results in loss of voice production by normal means. In evaluating organic loss of speech (see 2.09), ability to produce speech by any means includes the use of mechanical or electronic devices. Impairment of speech due to neurologic disorders should be evaluated under 11.00-11.19.

2.01 Category of Impairments, Special Senses and Speech

2.02 *Impairment of central visual acuity.* Remaining vision in the better eye after best correction is 20/200 or less.

2.03 *Contraction of peripheral visual fields in the better eye.*

A. To 10° or less from the point of fixation; or

B. So the widest diameter subtends an angle no greater than 20°; or

C. To 20 percent or less visual field efficiency.

2.04 *Loss of visual efficiency.* Visual efficiency of better eye after best correction 20 percent or less. (The percent of remaining visual efficiency = the product of the percent of remaining central visual efficiency and the percent of remaining visual field efficiency.)

2.05 *Complete homonymous hemianopsia* (with or without macular sparing). Evaluate under 2.04.

2.06 *Total bilateral ophthalmoplegia.*

2.07 *Disturbance of labyrinthine-vestibular function (including Meniere's disease)*, characterized by a history of frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing. With both A and B:

A. Disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests; and

B. Hearing loss established by audiometry.

2.08 *Hearing impairments* (hearing not restorable by a hearing aid) manifested by:

A. Average hearing threshold sensitivity for air conduction of 90 decibels or greater and for bone conduction to corresponding maximum levels, in the better ear, determined by the simple average of hearing threshold levels at 500, 1000 and 2000 hz. (see 2.00B1); or

B. Speech discrimination scores of 40 percent or less in the better ear;

2.09 *Organic loss of speech* due to any cause with inability to produce by any means speech which can be heard understood and sustained.

Table No. 1 — Percentage of Central Visual Efficiency Corresponding to Central Visual Acuity Notations for Distance in the Phakic and Aphakic Eye (Better Eye)

Snellen		Percent central visual efficiency		
English	Metric	Phakic ¹	Aphakic monocular ²	Aphakic binocular ³
20/16	6/5	100	50	75
20/20	6/6	100	50	75
20/25	6/7.5	95	47	71
20/32	6/10	90	45	67
20/40	6/12	85	42	64
20/50	6/15	75	37	56
20/64	6/20	65	32	49
20/80	6/24	60	30	45
20/100	6/30	50	25	37
20/125	6/38	40	20	30
20/160	6/48	30	22
20/200	6/60	20

Column and Use.

¹ Phakic. — 1. A lense is present in both eyes. 2. A lense is present in the better eye and absent in the poorer eye. 3. A lense is present in one eye and the other eye is enucleated.

² Monocular. — 1. A lense is absent in the better eye and present in the poorer eye. 2. The lenses are absent in both eyes; however, the central visual acuity in the poorer eye after best correction is 20/200 or less. 3. A lense is absent from one eye and the other eye is enucleated.

³ Binocular. — 1. The lenses are absent from both eyes and the central visual acuity in the poorer eye after best correction is greater than 20/200.

[CHART OMITTED]

Table No. 2—Chart of Visual Field Showing Extent of Normal Field and Method of Computing Percent of Visual Field Efficiency

1. Diagram of right eye illustrates extent of normal visual field as tested on standard perimeter at 3/330 (3 mm. white disc at a distance of 330 mm.) under 7 foot-candles illumination. The sum of the eight principal meridians of this field total 500°.

2. The percent of visual field efficiency is obtained by adding the number of degrees of the eight principal meridians of the contracted field and dividing by 500. Diagram of left eye illustrates visual field contracted to 30° in the temporal and down and out meridians and to 20° in the remaining six meridians. The percent of visual field efficiency of this field is: $6 \times 20 + 2 \times 30 = 180 \div 500 = 0.36$ or 36 percent remaining visual field efficiency, or 64 percent loss.

3.00 RESPIRATORY SYSTEM

A. *Introduction:* Impairments caused by the chronic disorder of the respiratory system generally result from irreversible loss of pulmonary functional capacity (ventilatory impairment, gas exchange impairment, or a combination of both). The most common symptom attributable to these disorders is dyspnea on exertion. Cough, wheezing, sputum production, hemoptysis, and chest pain may also occur, but need not be present. However, since these symptoms are common to many other diseases, evaluation of impairments of the respiratory system requires a history, physical examination, and chest roentgenogram to establish the diagnosis of a chronic respiratory disorder. Pulmonary function testing is required to provide a basis for

assessing the impairment, once the diagnosis is established by appropriate clinical findings.

Alteration of ventilatory function may be due primarily to chronic obstructive pulmonary disease (emphysema, chronic bronchitis, chronic asthmatic bronchitis) or restrictive disorders with primary loss of lung volume (pulmonary resection, thoracoplasty, chest cage deformity as seen in kyphoscoliosis), or infiltrative interstitial disorders (diffuse fibrosis). Impairment of gas exchange without significant airway obstruction may be produced by interstitial disorders (diffuse fibrosis). Primary disease of pulmonary circulation may produce pulmonary vascular hypertension and, eventually, heart failure. Whatever the mechanism, any chronic progressive pulmonary disorder may result in cor pulmonale or heart failure. Chronic infection caused, most frequently by mycobacterial or mycotic organisms, may produce extensive lung destruction resulting in marked loss of pulmonary functional capacity. Some disorders such as bronchiectasis and asthma may be characterized by acute, intermittent illnesses of such frequency and intensity that they produce a marked impairment apart from intercurrent functional loss, which may be mild.

Most chronic pulmonary disorders may be adequately evaluated on the basis of history, physical examination, chest roentgenogram, and ventilatory function tests. Direct assessment of gas exchange by exercise arterial blood gas determination or diffusing capacity is required only in specific relatively rare circumstances, depending on the clinical features and specific diagnosis.

B. *Mycobacterial and mycotic infections of the lung* will be evaluated on the basis of the resulting impairment to pulmonary function. Evidence of infectious or active mycobacterial or mycotic infection, such as positive cultures, increasing lesions, or cavitation, is not, by itself,

a basis for determining that the individual has a severe impairment which is expected to last 12 months. However, if these factors are abnormally persistent, they should not be ignored. For example, in those unusual cases where there is evidence of persistent pulmonary infection caused by mycobacterial or mycotic organisms for a period closely approaching 12 consecutive months, the clinical findings, complications, treatment considerations, and prognosis must be carefully assessed to determine whether, despite the absence of impairment of pulmonary function, the individual has a severe impairment that can be expected to last for 12 consecutive months.

C. *When a respiratory is episodic in nature*, as may occur in complications of bronchiectasis and asthmatic bronchitis, the frequency of severe episodes despite prescribed treatment is the criterion for determining the level of impairment. Documentation for episodic asthma should include the hospital or emergency room records indicating the dates of treatment, clinical findings on presentation, what treatment was given and for what period of time, and the clinical response. Severe attacks of episodic asthma, as listed in section 3.03B, are defined as prolonged episodes lasting at least several hours, requiring intensive treatment such as intravenous drug administration or inhalation therapy in a hospital or emergency room.

D. *Documentation of ventilatory function tests.* The results of ventilatory function studies for evaluation under tables I and II should be expressed in liters or liters per minute (BTPS). The reported one second forced expiratory volume (FEV₁) should represent the largest of at least three attempts. One satisfactory maximum voluntary ventilation (MVV) is sufficient. The MVV should represent the observed value and should not be calculated from FEV₁. These studies should be repeated after administration of a nebulized bronchodilator unless the prebroncho-

dilator values are 80 percent or more of predicted normal values or the use of bronchodilators is contraindicated. The values in tables I and II assume that the ventilatory function studies were not performed in the presence of wheezing or other evidence of bronchospasm or, if these were present at the time of the examination, that the studies were repeated after administration of a bronchodilator. Ventilatory function studies performed in the presence of bronchospasm, without use of bronchodilators, cannot be found to meet the requisite level of severity in tables I and II.

The appropriately labeled spirometric tracing, showing distance per second on the abscissa and the distance per liter on the ordinate, must be incorporated in the file. The manufacturer and model number of the device used to measure and record the ventilatory function should be stated. If the spirogram was generated other than by direct pen linkage to a mechanical displacement-type spirometer, the spirometric tracing must show the calibration of volume units through mechanical means such as would be obtained using a giant syringe. The FEV₁ must be recorded at a speed of at least 20 mm. per second. Calculation of the FEV₁ from a flow volume loop is not acceptable. The recording device must provide a volume excursions of at least 10 mm. per liter. The MVV should be represented by the tidal excursions measured over a 10- to 15-second interval. Tracings showing only cumulative volume for the MVV are not acceptable. The ventilatory function tables are based on measurement of the height of the individual without shoes. Studies should not be performed during or soon after an acute respiratory illness. A statement should be made as to the individual's ability to understand the directions and cooperate in performing the test.

E. *Documentation of chronic impairment of gas exchange—Arterial blood gases and exercise tests.*

1. *Introduction:* Exercise tests with measurement of arterial blood gases at rest and during exercise should be purchased when not available as evidence of record in cases in which there is documentation of chronic pulmonary disease, but the existing evidence, including properly performed ventilatory function tests, is not adequate to evaluate the level of the impairment. Before purchasing arterial blood gas tests, medical history, physical examination, report of chest roentgenogram, ventilatory function tests, electrocardiographic tracing, and hematocrit must be obtained and should be evaluated by a physician competent in pulmonary medicine. Arterial blood gas tests should not be purchased where full development short of such purchase reveals that the impairment meets or equals any other listing or when the claim can be adjudicated on some other basis. Capillary blood analysis for PO_2 or PCO_2 is not acceptable. Analysis of arterial blood gases obtained after exercise is stopped is not acceptable.

Generally individuals with an FEV_1 greater than 2.5 liters or an MVV greater than 100 liters per minute would not be considered for blood gas studies unless diffuse interstitial pulmonary fibrosis was noted on chest X-ray or documented by tissue diagnosis. The exercise test facility should be provided with the clinical reports, report of chest roentgenogram, and spirometry results obtained by the DDS. The testing facility should determine whether exercise testing is clinically contraindicated. If an exercise test is clinically contraindicated, the reason for exclusion from the test should be stated in the report of the exercise test facility.

2. *Methodology.* Individuals considered for exercise testing first should have resting PaO_2 , $PaCO_2$, and pH determinations by the testing facility. The samples should

be obtained in the sitting or standing position. The individual should be exercised under steady state conditions, preferably on a treadmill for a period of 6 minutes at a speed and grade providing a workload of approximately 17 ml. O_2 /kg./min. If a bicycle ergometer is used, an exercise equivalent of 450 kgm./min., or 75 watts, should be used. At the option of the facility, a warm-up period of treadmill walking may be performed to acquaint the applicant with the procedure. If, during the warm-up period, the individual cannot exercise at the designated level, a lower speed and/or grade may be selected in keeping with the exercise capacity estimate. The individual should be monitored by electrocardiogram throughout the exercise and representative strips taken to provide heart rate in each minute of exercise. During the 5th or 6th minute of exercise, an arterial blood gas sample should be drawn and analyzed for PO_2 , PCO_2 , and pH. If the facility has the capability, and at the option of the DDS and the facility, minute ventilation (BTPS) and oxygen consumption per minute (STPD) and CO_2 production (STPD) should be measured during the 5th or 6th minute of exercise. If the individual fails to complete 6 minutes of exercise, the facility should comment on the reason.

The report should contain representative strips of electrocardiograms taken during the exercise, hematocrit, resting and exercise arterial blood gas value, speed and grade of the treadmill or bicycle ergometer exercise level in watts or kgm./min., and duration of exercise. The altitude of the test site, barometric pressure, and normal range of blood gas values for that facility should also be reported.

3. *Evaluation.* Three tables are provided in Listing 3.02C1 for evaluation of arterial blood gas determinations at rest and during exercise. The blood gas levels in Listing 3.02C1, Table III-A, are applicable at test sites situated at less than 3,000 feet above sea level. The blood gas levels in

Listing 3.02C1, Table III-B, are applicable at test sites situated at 3,000 through 6,000 feet above sea level. The blood gas levels in Listing 3.02C1, Table III-C, are applicable for test sites over 6,000 feet above sea level. Tables III-B and C, take into account the lower blood PaO_2 normally found in individuals tested at the higher altitude. When the barometric pressure is unusually high for the altitude at the time of testing, consideration should be given to those cases in which the PaO_2 falls slightly above the requirements of Table III-A, III-B, or III-C, whichever is appropriate for the altitude at which testing was performed.

3.01 Category of Impairments, Respiratory

3.02 *Chronic Pulmonary Insufficiency.*

With:

A. Chronic obstructive pulmonary disease (due to any cause). With: Both FEV_1 and MVV equal to or less than values specified in Table I corresponding to the person's height without shoes.

Table I

Height without shoes (inches)	FEV ₁ and MVV	
	Equal to or (L, BTPS)	(MBC) equal to or less than (L/min., BTPS)
60 or less	1.0	40
61-63	1.1	44
64-65	1.2	48
66-67	1.3	52
68-69	1.4	56
70-71	1.5	60
72 or more	1.6	64

or

B. *Chronic restrictive ventilatory disorders.* With: Total vital capacity equal to or less than values specified in Table II corresponding to the person's height without shoes. In severe kyphoscoliosis, the measured span between the fingertips when the upper extremities are abducted 90 degrees should be substituted for height.

Table II

Height without shoes (inches)	VC equal to or less than (L, BTPS)
60 or less	1.2
61-63	1.3
64-65	1.4
66-67	1.5
68-69	1.6
70-71	1.7
72-or more	1.8

or

C. Chronic impairment of gas exchange (due to any cause). With:

1. Stead-state exercise blood gases demonstrating values of PaO_2 and simultaneously determined PaCO_2 , measured at a workload of approximately 17 ml. $\text{O}_2/\text{kg.}/\text{min.}$ or less of exercise, equal to or less than the values specified in Table III-A or III-B or III-C.

Table III - A

[Applicable at test sites less than, 3,000 feet above sea level]

Arterial PCO ₂ (mm. Hg)	Arterial PO ₂ and equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

Table III - B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg)	Arterial PCO ₂ and equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

Table III - C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg)	Arterial PO ₂ and equal to or less than (mm. Hg)
30 or below	56
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

or

2. Diffusing capacity for the lungs for carbon monoxide less than 6 ml./mm. Hg/min. (steady-state methods) or less than 9 ml./mm. Hg/min. (single breath method) or less than 30 percent of predicted normal. (All method, actual values, and predicted normal values for the methods used should be reported.): or

D. Mixed obstructive ventilatory and gas exchange impairment. Evaluate under the criteria in 3.02A, B, and C.

3.03 Asthma. With:

A. Chronic asthmatic bronchitis. Evaluate under the criteria for chronic obstructive ventilatory impairment in 3.02A, or

B. Episodes of severe attacks (See 3.00C), in spite of prescribed treatment, occurring at least once every 2 months or on an average of at least 6 times a year, and prolonged expiration with wheezing or rhonchi on physical examination between attacks.

3.06 *Pneumoconiosis (demonstrated by roentgenographic evidence)*. Evaluate under criteria in 3.02.

3.07 *Bronchiectasis (demonstrated by radio-opaque material)*. With:

A. Episodes of acute bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) occurring at least every 2 months; or

B. Impairment of pulmonary function due to extensive disease should be evaluated under the applicable criteria in 3.02.

3.08 *Mycobacterial infection of the lung*. Impairment of pulmonary function due to extensive disease should be evaluated under appropriate criteria in 3.02.

3.09 *Mycotic infection of the lung*. Impairment of pulmonary function due to extensive disease should be evaluated under the appropriate criteria in 3.02.

3.11 *Cor pulmonale, or pulmonary vascular hypertension*. Evaluate under the criteria in 4.02D.

4.00 CARDIOVASCULAR SYSTEM

A. *Severe cardiac impairment* results from one or more of three consequences of heart disease; (1) congestive heart failure; (2) ischemia (with or without necrosis) of heart muscle; (3) conduction disturbances and/or arrhythmias resulting in cardiac syncope.

With diseases of arteries and veins, severe impairment may result from disorders of the vasculature in the central nervous system, eyes, kidneys, extremities, and other organs.

The criteria for evaluating impairment resulting from heart diseases or diseases of the blood vessels are based on symptoms, physical signs and pertinent laboratory findings.

B. *Congestive heart failure* is considered in the Listing under one category whatever the etiology (i.e., arteriosclerotic, hypertensive, rheumatic, pulmonary, congenital, or other organic heart diseases). Congestive heart failure is not considered to have been established for the purpose of 4.02 unless there is evidence of vascular congestion such as hepatomegaly or peripheral or pulmonary edema which is consistent with clinical diagnosis. (Radiological description of vascular congestion, unless supported by appropriate clinical evidence, should not be construed as pulmonary edema.) The findings of vascular congestion need not be present at the time of adjudication (except for 4.02A), but must be casually related to the current episode of marked impairment. The findings other than vascular congestion must be persistent.

Other congestive, ischemic, or restrictive (obstructive) heart diseases such as caused by cardiomyopathy or aortic stenosis may result in significant impairment due [sic] to congestive heart failure, rhythm disturbances, or ventricular outflow obstruction in the absence of left ventricular enlargement as described in 4.02B1. However, the ECG criteria as defined in 4.02B2 should be fulfilled. Clinical findings such as symptoms [sic] of dyspnea, fatigue, rhythm disturbances, etc., should be documented and the diagnosis confirmed by echocardiography or at cardiac catheterization.

C. *Hypertensive vascular diseases* does not result in severe impairment unless it causes severe damage to one or more of four end organs; heart, brain, kidneys, or eyes. (retinae). The presence of such damage must be established by appropriate abnormal physical signs and laboratory findings as specified in 4.02 or 4.04, or for the body system involved.

D. *Ischemic heart diseases* may result in a marked impairment due to chest pain. Description of the pain must

contain the clinical characteristics as discussed under 4.00E. In addition, the clinical impression of chest pain of cardiac origin must be supported by objective evidence as described under 4.00 F, G, or H.

E. *Chest pain of cardiac origin* is considered to be pain which is precipitated by effort and promptly relieved by sublingual nitroglycerin or rapid-acting nitrates or rest. The character of the pain is classically described as crushing squeezing, burning, or oppressive pain located in the chest. Excluded is sharp, sticking or rhythmic pain. Pain occurring on exercise should be described specifically as to usual inciting factors (kind and degree), character, location, radiation, duration, and responses to nitroglycerin or rest.

So-called "anginal equivalent" locations manifested by pain in the throat, arms, or hands have the same validity as the chest pain described above. Status anginosus and variant angina of the Prinzmetal type (e.g., rest angina with transitory ST elevation on electrocardiogram) will be considered to have the same validity as classical angina pectoris as described above. Shortness of breath as an isolated finding should not be considered as an anginal equivalent.

Chest pain that appears to be of cardiac origin may be caused by noncoronary conditions. Evidence for the latter should be actively considered in determining whether the chest pain is of cardiac origin. Among the more common conditions which may masquerade as angina are gastrointestinal tract lesions such as biliary tract disease, esophagitis, hiatal hernia, peptic ulcer, and pancreatitis; and musculoskeletal lesions such as costochondritis and cervical arthritis.

F. *Documentation of electrocardiography.*

1. *Electrocardiograms obtained at rest* must be submitted in the original or a legible copy of a 12-lead tracing

appropriately labeled, with the standardization inscribed on the tracing. Alteration in standardization of specific leads (such as to accommodate large QRS amplitudes) must be shown on those leads.

The effect of drugs, electrolyte imbalance, etc., should be considered as possible noncoronary causes of ECG abnormalities, especially those involving the ST segment. If needed and available, pre-drug (especially predigitalis) tracing should be obtained.

The term "ischemic" is used in 4.04 to describe a pathologic ST deviation. Nonspecific repolarization changes should not be confused with ischemic configurations or a current of injury.

Detailed descriptions or computer interpretations without the original or legible copies of the ECG are not acceptable.

2. *Electrocardiograms obtained in conjunction with exercise tests* must include the original tracings or a legible copy of appropriate leads obtained before, during, and after exercise. Test control tracings, taken before exercise. Test control tracings, taken before exercise in the upright position, must be obtained. An ECG after 20 seconds of vigorous hyperventilation should be obtained. A post-hyperventilation tracing may be essential for the proper evaluation of an "abnormal" test in certain circumstances, such as in women with evidence of mitral valve prolapse. A tracing should be taken at approximately 5 METs of exercise and at the time the ECG becomes abnormal according to the criteria in 4.04A. The time of onset of these abnormal changes must be noted, and the ECG tracing taken at the time should be obtained. Exercise histograms without the original tracings or legible copies are not acceptable.

Whenever electrocardiographically documented stress test data are submitted, irrespective of the type, the stand-

ardization must be inscribed on the tracings and the strips must be labeled appropriately, indicating the times recorded. The degree of exercise achieved, the blood pressure levels during the test, and any reason for terminating the test must be included in the report.

G. Exercise testing.

1. *When to purchase.* Since the results of a treadmill exercise test are the primary basis for adjudicating claims under 4.04, they should be included in the file whenever they have been performed. There are also circumstances under which it will be appropriate to purchase exercise tests. Generally, these are limited to claims involving chest pain which is considered to be of cardiac origin but without corroborating ECG or other evidence of ischemic heart disease.

Exercise test should not be purchased in the absence of alleged chest pain of cardiac origin. Even in the presence of an allegation of chest pain of cardiac origin, an exercise test should not be purchased where full development short of such a purchase reveals that the impairment meets or equals any Listing or the claim can be adjudicated on some other basis.

2. *Methodology.* When an exercise test is purchased, it should be a treadmill type using a continuous progressive multistage regimen. The targeted heart rate should be not less than 85 percent of the maximum predicted heart rate unless it becomes hazardous to exercise to the heart rate or becomes unnecessary because the ECG meets the criteria in 4.04A at a lower heart rate (see also 4.00F.2). Beyond these requirements, it is prudent to accept the methodology of a qualified, competent test facility. In any case, a precise description of the protocol that was followed must be provided.

3. *Limitations of exercise testing.* Exercise testing should not be purchased for individuals who have the fol-

lowing: unstable progressive angina pectoris; recent onset (approximately 2 months) of angina; congestive heart failure; uncontrolled serious arrhythmias (including uncontrolled auricular fibrillation); second or third-degree heart block; Wolff-Parkinson-White syndrome; uncontrolled marked hypertension; marked aortic stenosis; marked pulmonary hypertension; dissecting or ventricular aneurysms; acute illness; limiting neurological or musculoskeletal impairments; or for individuals on medication where performance of stress testing may constitute a significant risk.

The presence of noncoronary or nonischemic factors which may influence the ECG response to exercise include hypokalemia, hyperventilation, vasoregulatory asthenia, significant anemia, left bundle branch block, and other heart disease, particularly valvular.

Digitalis may cause ST segment abnormalities at rest, during, and after exercise. Digitalis-related ST depression, present at rest, may become accentuated and result in false interpretations of the ECG taken during or after exercise test.

4. *Evaluation.* Where the evidence includes the results of a treadmill exercise test, this evidence is the primary basis for adjudicating claims under 4.04. For purposes of this Social Security disability program, treadmill exercise testing will be evaluated on the basis of the level at which the test becomes positive in accordance with the ECG criteria in § 404A. However, the significance of findings of a treadmill exercise test must be considered in light of the clinical course of the disease which may have occurred subsequent to performance of the exercise test. The criteria in 4.04B are not applicable if there is documentation of an acceptable treadmill exercise test, it [sic] there is no evidence of a treadmill exercise test or if the test is not acceptable, the criteria in 4.04B should be used. The

level of exercise is considered in terms of multiples of MET's (metabolic equivalent units). One MET is the basal O_2 requirement of the body in an inactive state, sitting quietly [sic]. It is considered by most authorities to be approximately 3.5 ml. O_2 /kg./min.

H. *Angiographic evidence.*

1. *Coronary arteriography.* This procedure is not to be purchased by the Social Security Administration. Should the results of such testing be available, the report should be considered as to the quality and kind of data provided and its applicability to the requirements of the Listing of Impairments. A copy of the report of the catheterization and ancillary studies should be obtained. The report should provide information as to the technique used, the method of assessing coronary lumen diameter, and the nature and location of any obstructive lesions.

It is helpful to know the method used, the number of projections, and whether selective engagement of each coronary vessel was satisfactorily accomplished. It is also important to know whether the injected vessel was entirely and uniformly opacified, thus avoiding the artifactual appearance of narrowing or an obstruction.

Coronary artery spasm induced by intracoronary catheterization is not to be considered as evidence of ischemic heart disease.

Estimation of the functional significance of an obstructive lesion may also be aided by description of how well the distal part of the vessel is visualized. Some patients with significant proximal coronary atherosclerosis have well-developed large collateral blood supply to the distal vessels without evidence of myocardial damage or ischemia, even under conditions of severe stress.

2. *Left ventriculography.* The report should describe the local contractility of the myocardium as may be evident from areas of hypokinesia, dyskinesia, or akinesia;

and the overall contractility of the myocardium as measured by the ejection fraction.

3. *Proximal coronary arteries* (see 4.04B7) will be considered as the:

- a. Right coronary artery proximal to the acute marginal branch; or
- b. Left anterior descending coronary artery proximal to the first septal perforator; or
- c. Left circumflex coronary artery proximal to the first obtuse marginal branch.

1. *Results of other tests.* Information from adequate reports of other tests such as radionuclide studies or echocardiography should be considered where that information is comparable to the requirements in the listing. An ejection fraction measured by echocardiography is not determinative, but may be given consideration in the context of associated findings.

J. *Major surgical procedures.* The amount of function restored and the time required to effect improvement after heart or vascular surgery vary with the nature and extent of the disorder, the type of surgery, and other individual factors. If the criteria described for heart or vascular disease are met, proposed heart or vascular surgery (coronary artery bypass procedure, valve replacement, major arterial grafts, etc.) does not militate against a finding of disability with subsequent assessment postoperatively.

The usual time after surgery for adequate assessment of the results of surgery is considered to be approximately 3 months. Assessment of the magnitude of the impairment following surgery requires adequate documentation of the pertinent evaluations and tests performed following surgery, such as an interval history and physical examination, with emphasis on those signs and symptoms which might have changed postoperatively, as well as X-rays and electrocardiograms. Where treadmill exercise tests or

angiography have been performed following the surgical procedure, the results of these tests should be obtained.

Documentation of the preoperative evaluation and a description of the surgical procedure are also required. The evidence should be documented from hospital records (catheterization reports, coronary arteriographic reports, etc.) and the operative note.

Implantation of a cardiac pacemaker is not considered a major surgical procedure for purposes of this section.

K. *Evaluation of peripheral arterial disease.* The evaluation of peripheral arterial disease is based on medically acceptable clinical findings providing adequate history and physical examination findings describing the impairment, and on documentation of the appropriate laboratory techniques. The specific findings stated in Listing 4.13 represent the level of severity of that impairment; these findings, by themselves, are not intended to represent the basis for establishing the clinical diagnosis. The level of the impairment is based on the symptomatology, physical findings, Doppler studies before and after a standard exercise test, and/or angiographic findings.

The requirements for evaluation of peripheral arterial disease in Listing 4.13B are based on the ratio of systolic blood pressure at the ankle, determined by Doppler study, to the systolic blood pressure at the brachial artery determined at the same time. Results of plethysmographic studies, or other techniques providing systolic blood pressure determinations at the ankle, should be considered where the information is comparable to the requirements in the listing.

Listing 4.13B.1 providing for determining that the listing is met when the resting ankle/brachia systolic blood pressure ratio is less than 0.50. Listing 4.13B.2 provides additional criteria for evaluating peripheral arterial impairment on the basis of exercise studies when the resting

ankle/brachial systolic blood pressure ratio is 0.50 or above. The results of exercise studies should describe the level of exercise (e.g., speed and grade of the treadmill settings), the duration of exercise, symptoms during exercise, the reasons for stopping exercise if the expected level of exercise was not attained, blood pressures at the ankle and other pertinent levels measured after exercise, and the time required to return the systolic blood pressure toward or to, the preexercise level. When exercise Doppler studies are purchased by the Social Security Administration, it is suggested that the requested exercise be on a treadmill at 2 mph. on a 12 percent grade for 5 minutes. Exercise studies should not be performed on individuals for whom exercise is contraindicated. The methodology of a qualified, competent facility should be accepted. In any case, a precise description of the protocol that was followed must be provided.

It must be recognized that application of the criteria in Listing 4.13B may be limited in individuals who have severe calcific (Monckeberg's) sclerosis of the peripheral arteries or severe small vessel disease in individuals with diabetes mellitus.

4.01 Category of Impairments, Cardiovascular System.

4.02 *Congestive heart failure (manifested by evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema).* With:

A. Persistent congestive heart failure on clinical examination despite prescribed therapy; or

B. Persistent left ventricular enlargement and hypertrophy documented by both:

1. Extension of the cardiac shadow (left ventricle) to the vertebral column on a left lateral chest roentgenogram; and

2. ECG showing QRS duration less than 0.12 second with S_{V1} plus R_{V5} (or R_{V6}) of 35 mm. or greater *and* ST segment depressed more than 0.5 mm. *and* low, diphasic or inverted T waves in leads with all tall R waves; or

C. Persistent "mitral" type heart involvement documented by left atrial enlargement shown by double shadow on PA chest roentgenogram (or characteristic distortion of barium-filled esophagus) and either;

1. ECG showing QRS duration less than 0.12 second with S_{V1} plus R_{V5} (or R_{V6}) of 35 mm. or greater *and* ST segment depressed more than 0.5 mm. *and* low, diphasic or inverted T waves in leads with tall R waves; or

2. ECG evidence of right ventricular hypertrophy with R wave of 5.0 mm. or greater in lead V_1 *and* progressive decrease in R/S amplitude from lead V_1 to V_5 or V_6 ; or

D. Cor pulmonale (non-acute) documented by both:

1. Right ventricular enlargement (or prominence of the right out-flow trace) on chest roentgenogram or fluoroscopy; and

2. ECG evidence of right ventricular hypertrophy with R wave of 5.0 mm. or greater in lead V_1 *and* progressive decrease in R/S amplitude from lead V_1 to V_5 or V_6 .

4.03 *Hypertensive vascular disease.* Evaluate under 4.02 04 4.04 or under the criteria for the affected body system.

4.04 *Ischemic heart disease with chest pain or cardiac origin as described in 4.00E* With:

A. Treadmill exercise test (see 4.00 F and (G) demonstrating one of the following at an exercise level of 5 METs or less:

1. Horizontal or downsloping depression (from the standing control) of the ST segment to 1.0 mm. or greater, lasting for at least 0.08 second after the J junction, and clearly discernible in at least two consecutive complexes which are on a level baseline in any lead; or

2. Junctional depression occurring during exercise, remaining depressed (from the standing control) to 2.0 mm. or greater for at least 0.08 second after the J junction (the so called slow upsloping ST segment), and clearly discernible in at least two consecutive complexes which are on a level baseline in any lead; or

3. Premature ventricular systoles which are multiform or bidirectional or are sequentially inscribed (3 or more); or

4. ST segment elevation (from the standing control) to 1 mm. or greater; or

5. Development of second or third degree heart block; or

B. In the absence of a report of an acceptable treadmill exercise test (see 4.00G), one of the following:

1. Transmural myocardial infarction exhibiting a QS pattern or a Q wave with amplitude at least $\frac{1}{3}$ rd of R wave and with a duration of 0.04 second or more. (If these are present in leads III and a VF only, the requisite Q wave findings must be shown, by labelled tracing, to persist on deep inspiration); or

2. Resting ECG findings showing ischemic-type (see § 4.00F1) depression of ST segment to more than 0.5 mm. in either (a) leads I and a VL and V_6 or (b) leads II and III and a VF or (c) leads V_3 through V_6 ; or

3. Resting ECG findings showing an ischemic configuration or current of injury (see 4.00F1) with ST segment elevation to 2 mm. or more in either (a) leads I and a VL and V_6 or (b) leads II and III and a VF or (c) leads V_3 through V_6 ; or

4. Resting ECG findings show symmetrical inversion of T waves to 5.0 mm. or more in any two leads except leads III or a VR or V_1 or V_2 ; or

5. Inversion of T wave to 1.0 mm. or more in any of leads I, II, aVL, V_2 to V_6 *and* R wave of 5.0 mm. or more

in lead aVL *and* R wave greater than S wave in lead aVF;
or

6. "Double" Master Two-Step test demonstrating one of the following:

a. Ischemic depression of ST segment to more than 0.5 mm. lasting for at least 0.08 second beyond the J junction and clearly discernible in at least two consecutive complexes which are on a level baseline in any lead; or

b. Development of a second or third degree heart block; or

7. Angiographic evidence (see 4.00H) (obtained independent of Social Security disability evaluation) showing one of the following:

a. 50 percent or more narrowing of the left main coronary artery; or

b. 70 percent or more narrowing of a *proximal* coronary artery (see 4.00H3) (excluding the left main coronary artery); or

c. 50 percent or more narrowing involving a long (greater than 1 cm.) segment of a proximal coronary artery or multiple proximal coronary arteries; or

8. Akinetic or hypokinetic myocardial wall or septal motion with left ventricular ejection fraction of 30 percent or less measured by contrast or radio-isotopic ventriculographic methods; or

C. Resting ECG findings showing left bundle branch block as evidenced by QRS duration of 0.12 second or more in leads I, II, or III *and* R peak duration of 0.06 second or more in leads I, aVL, V₅, or V₆, unless there is a coronary angiogram of record which is negative (see criteria in 4.04B7).

4.05 *Recurrent arrhythmias* (not due to digitalis toxicity) resulting in uncontrolled repeated episodes of cardiac syncope and documented by resting or ambulatory (Holter) electrocardiography.

4.09 *Myocardopathies, rheumatic or syphilitic heart disease*. Evaluate under the criteria in 4.02, 4.04, 4.05, or 11.04.

4.1i *Aneurysm of aorta or major branches* (demonstrated by roentgenographic evidence). With:

A. Acute or chronic dissection not controlled by prescribed medical or surgical treatment; or

B. Congestive heart failure as described under the criteria in 4.02; or

C. Renal failure as described under the criteria in 6.02; or

D. Repeated syncopal episodes.

4.12 *Chronic venous insufficiency* of the lower extremity with incompetency or obstruction of the deep venous return, associated with superficial varicosities, extensive brawny edema, stasis dermatitis, and recurrent or persistent ulceration which has not healed following at least 3 months of prescribed medical or surgical therapy.

4.13 *Peripheral arterial disease*. With:

A. Intermittent claudication with failure to visualize (on arteriogram obtained independent of Social Security disability evaluation) the common femoral or deep femoral artery in one extremity; or

B. Intermittent claudication with marked impairment of peripheral arterial circulation as determined by Doppler studies showing:

1. Resting ankle/brachial systolic blood pressure ratio of less than 0.50; or

2. Decrease in systolic blood pressure at ankle or exercise (see 4.00K) to 50 percent or more of preexercise level *and* requiring 10 minutes or more to return to preexercise [sic] level; or

C. Amputation at or above the tarsal region due to peripheral arterial disease.

5.00 DIGESTIVE SYSTEM

A. *Disorders of the digestive system* which result in a marked impairment usually do so because of interference with nutrition, multiple recurrent inflammatory lesions, or complications of disease, such as fistulae, abscesses, or recurrent obstruction. Such complications usually respond to treatment. These complications must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months.

B. *Malnutrition or weight loss from gastrointestinal disorders.* When the primary disorder of the digestive tract has been established (e.g. enterocolitis, chronic pancreatitis, postgastrointestinal resection, or esophageal stricture, stenosis, or obstruction), the resultant interference with nutrition will be considered under the criteria in 5.08. This will apply whether the weight loss is due to primary or secondary disorders of malabsorption, malassimilation or obstruction. However, weight loss not due to diseases of the digestive tract, but associated with psychiatric or primary endocrine or other disorders, should be evaluated under the appropriate criteria for the underlying disorder.

C. *Surgical diversion of the intestinal tract*, including colostomy or ileostomy, are not listed since they do not represent impairments which preclude all work activity if the individual is able to maintain adequate nutrition and function of the stoma. Dumping syndrome which may follow gastric resection rarely represents a marked impairment which would continue for 12 months. Peptic ulcer disease with recurrent ulceration after definitive surgery ordinarily responds to treatment. A recurrent ulcer after definitive surgery must be demonstrated on repeated upper gastrointestinal roentgenograms or gastroscopic ex-

aminations despite therapy to be considered a severe impairment which will last for at least 12 months. Definitive surgical procedures are those designed to control the ulcer disease process (i.e., vagotomy and pyloroplasty, subtotal gastrectomy, etc.). Simple closure of a perforated ulcer does not constitute definitive surgical therapy for peptic ulcer disease.

5.01 Category of Impairments, Digestive System

5.02 *Recurrent upper gastrointestinal hemorrhage from undetermined cause* with anemia manifested by hematocrit of 30 percent or less on repeated examinations.

5.03 *Stricture, stenosis, or obstruction of the esophagus (demonstrated by X-ray or endoscopy)* with weight loss as described under § 5.08.

5.04 *Peptic ulcer disease (demonstrated by X-ray or endoscopy).* With:

A. Recurrent ulceration after definitive surgery persistent despite therapy; or

B. Inoperable fistula formation; or

C. Recurrent obstruction demonstrated by X-ray or endoscopy. [sic] or

D. Weight loss as described under § 5.08.

5.05 *Chronic liver disease (e.g., portal, postnecrotic, or biliary cirrhosis; chronic active hepatitis; Wilson's disease).* With:

A. Esophageal varices (demonstrated by X-ray or endoscopy) with a documented history of massive hemorrhage attributable to these varices. Consider under a disability for 3 years following the last massive hemorrhage; thereafter, evaluate the residual impairment; or

B. Performance of a shunt operation for esophageal varices. Consider under a disability for 3 years following surgery; thereafter, evaluate the residual impairment; or

C. Serum bilirubin of 2.5 mg. per deciliter (100 ml.) or greater persisting on repeated examinations for at least 5 months; or

D. Ascites, not attributable to other causes, recurrent or persisting for at least 5 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

E. Hepatic encephalopathy. Evaluate under the criteria in listing 12.02; or

F. Confirmation of chronic liver disease by liver biopsy (obtained independent of Social Security disability evaluation) and one of the following:

1. Ascites not attributable to other causes, recurrent or persisting for at least 3 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

2. Serum bilirubin of 2.5 mg. per deciliter (100 ml) or greater on repeated examinations for at least 3 months; or

3. Hepatic cell necrosis or inflammation, persisting for at least 3 months, documented by repeated abnormalities of prothrombin time and enzymes indicative of hepatic dysfunction.

5.06 *Chronic ulcerative or granulomatous colitis (demonstrated by endoscopy, barium enema, biopsy, or operative findings).* With:

A. Recurrent bloody stools documented on repeated examinations and anemia manifested by hematocrit of 30 percent or less on repeated examinations; or

B. Persistent or recurrent systemic manifestations, such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess, fistula formation, or stenosis; or

D. Recurrence of findings of A, B, or C above after total colectomy; or

E. Weight loss as described under § 5.08.

5.07 *Regional enteritis (demonstrated by operative findings, barium studies, biopsy, or endoscopy).* With:

A. Persistent or recurrent intestinal obstruction evidenced by abdominal pain, distention, nausea, and vomiting and accompanied by stenotic areas of small bowel with proximal intestinal dilation; or

B. Persistent or recurrent systemic manifestations such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess or fistula formation; or

D. Weight loss as described under § 5.08.

5.08 *Weight loss due to any persisting gastrointestinal disorder:* (The following weights are to be demonstrated to have persisted for at least 3 months despite prescribed therapy and expected to persist at this level for at least 12 months.) With:

A. Weight equal to or less than the values specified in Table I or II; or

B. Weight equal to or less than the values specified in Table III or IV and one of the following abnormal findings on repeated examinations:

1. Serum albumin of 3.0 gm. per deciliter (100 ml.) or less; or

2. Hematocrit of 30 percent or less; or

3. Serum calcium of 8.0 mg. per deciliter (100 ml.) (4.0 mEq./L) or less; or

4. Uncontrolled diabetes mellitus due to pancreatic dysfunction with repeated hyperglycemia, hypoglycemia, or ketosis; or

5. Fat in stool of 7 gm. or greater per 24-hour stool specimen; or

6. Nitrogen in stool of 3 gm, [sic] or greater per 24-hour specimen; or

7. Persistent or recurrent ascites or edema not attributable to other causes.

Tables of weight reflecting malnutrition scaled according to height and sex — To be used only in connection with 5.08.

Table I — Men

Height (inches) ¹	Weight (pounds)
61	90
62	92
63	94
64	97
65	99
66	102
67	106
68	109
69	112
70	115
71	118
72	122
73	125
74	128
75	131
76	134

¹ Height measured without shoes.

Table II — Women

Height (inches) ¹	Weight (pounds)
58	77
59	79
60	82

Table II — Women — Continued

Height (inches) ¹	Weight (pounds)
61	84
62	86
63	89
64	91
65	94
66	98
67	101
68	104
69	107
70	110
71	114
72	117
73	120

¹ Height measured without shoes.

Table III — Men

Height (inches) ¹	Weight (pounds)
61	95
62	98
63	100
64	103
65	106
66	109
67	112
68	116
69	119
70	122
71	126
72	129

Table III — Men — Continued

Height (inches) ¹	Weight (pounds)
73	133
74	136
75	139
76	143

¹ Height measured without shoes.

Table IV — Women

Height (inches) ¹	Weight (pounds)
58	82
59	84
60	87
61	89
62	92
63	94
64	97
65	100
66	104
67	107
68	111
69	114
70	117
71	121
72	124
73	128

¹ Height measured without shoes.

6.00 GENITO-URINARY SYSTEM

A. *Determination of the presence of chronic renal disease will be based upon* (1) a history, physical examination, and laboratory evidence of renal disease, and (2) indications of its progressive nature or laboratory evidence of deterioration or renal function.

B. *Nephrotic Syndrome.* The medical evidence establishing the clinical diagnosis must include the description of extent of tissue edema, including pretibial, periorbital, or presacral edema. The presence of ascites, pleural effusion, pericardial effusion, and hydroarthrosis should be described if present. Results of pertinent laboratory tests must be provided. If a renal biopsy has been performed, the evidence should include a copy of the report of microscopic examination of the specimen. Complications such as severe orthostatic hypotension, recurrent infections or venous thromboses should be evaluated on the basis of resultant impairment.

C. *Hemodialysis, peritoneal dialysis, and kidney transplantation.* When an individual is undergoing periodic dialysis because of chronic renal disease, severity of impairment is reflected by the renal function prior to the institution of dialysis.

The amount of function restored and the time required to effect improvement in an individual treated by renal transplant depend upon various factors, including adequacy of post transplant renal function, incidence and severity of renal infection, occurrence of rejection crisis, the presence of systemic complications (anemia, neuropathy, etc.) and side effects of corticosteroids or immunosuppressive agents. A convalescent period of at least 12 months is required before it can be reasonably determined whether the individual has reached a point of stable medical improvement.

D. *Evaluate associated disorders and complications* according to the appropriate body system Listing.

6.01 Category of Impairments, Genito-Urinary System

6.02 Impairment of renal function, due to any chronic renal disease expected to last 12 months (e.g., hypertensive vascular disease, chronic nephritis, nephrolithiasis, polycystic disease, bilateral hydronephrosis, etc.) With:

A. Chronic hemodialysis or peritoneal dialysis necessitated by irreversible renal failure; or

B. Kidney transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 6.00C); or

C. Persistent elevation of serum creatine in to 4 mg. per deciliter (100 ml.) or greater or reduction of creatinine clearance to 20 ml. per minute (29 liters/24 hours) or less, over at least 3 months, with one of the following:

1. Renal osteodystrophy manifested by severe bone pain and appropriate radiographic abnormalities (e.g., osteitis fibrosa, marked osteoporosis, pathologic fractures); or

2. A clinical episode of pericarditis; or

3. Persistent motor or sensory neuropathy; or

4. Intractable pruritus; or

5. Persistent fluid overload syndrome resulting in diastolic hypertension (110 mm. or above) or signs of vascular congestion; or

6. Persistent anorexia with recent weight loss and current weight meeting the values in 5.08, Table III or IV; or

7. Persistent hematocrits of 30 percent or less.

6.06 *Nephrotic syndrome, with significant anasarca, persistent for at least 3 months despite prescribed therapy.* With:

A. Serum albumin of 3.0 gm. per deciliter (100 ml.) or less and proteinuria of 3.5 gm. per 24 hours or greater; or

B. Proteinuria of 10.0 gm. per 24 hours or greater.

7.00 HEMIC AND LYMPHATIC SYSTEM

A. *Impairment caused by anemia* should be evaluated according to the ability of the individual to adjust to the reduced oxygen carrying capacity of the blood. A gradual reduction in red cell mass, even to very low values, is often well tolerated in individuals with a healthy cardiovascular system.

B. *Chronicity is indicated by persistence* of the condition for at least 3 months. The laboratory findings cited must reflect the values reported on more than one examination over that 3-month period.

C. *Sickle cell disease* refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell disease, such as hemoglobin electrophoresis, must be included. Vasoocclusive or aplastic episodes should be documented by description of severity, frequency, and duration.

Major visceral episodes include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genito-urinary involvement, etc.

D. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory evidence. Prophylactic therapy such as with anti-hemophilic globulin (AHG) concentrate does not in itself imply severity.

E. *Acute leukemia.* Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The acute phase of chronic myelocytic (granulocytic) leukemia should be considered under the requirements for acute leukemia.

The criteria in 7.11 contain the designated duration of disability implicit in the finding of a listed impairment. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a marked impairment. The level of any remaining impairment must be evaluated on the basis of the medical evidence.

7.01 Category of Impairments, Hemic and Lymphatic System

7.02 *Chronic anemia (hematocrit persisting at 30 percent or less due to any cause).* With:

A. Requirement of one or more blood transfusions on an average of at least once every 2 months; or

B. Evaluation of the resulting impairment under criteria for the affected body system.

7.05 *Sickle cell disease, or one of its variants.* With:

A. Documented painful (thrombotic) crises occurring at least three times during the 5 months prior to adjudication; or

B. Requiring extended hospitalization (beyond emergency care) at least three times during the 12 months prior to adjudication; or

C. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

D. Evaluate the resulting impairment under the criteria for the affected body system.

7.06 *Chronic thrombocytopenia (due to any cause)* with platelet counts repeatedly below 40,000/cubic millimeter. With:

A. At least one spontaneous hemorrhage, requiring transfusion, within 5 months prior to adjudication; or

B. Intracranial bleeding within 12 months prior to adjudication.

7.07 *Hereditary telangiectasia* with hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.08 *Coagulation defects (hemophilia or a similar disorder)* with spontaneous hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.09 *Polycythemia vera (with erythrocytosis, splenomegaly, and leukocytosis or thrombocytosis).* Evaluate the resulting impairment under the criteria for the affected body system.

7.10 *Myelofibrosis (myeloproliferative syndrome).* With:

A. Chronic anemia. Evaluate according to the criteria of § 7.02; or

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication; or

C. Intractable bone pain with radiologic evidence of osteosclerosis.

7.11 *Acute leukemia.* Consider under a disability for 2½ years from the time of initial diagnosis.

7.12 *Chronic leukemia.* Evaluate according to the criteria of 7.02, 7.06, 7.10B, 7.11, 7.17 or 13.06A.

7.13 *Lymphomas.* Evaluate under the criteria in 13.06A.

7.14 *Macroglobulinemia or heavy chain disease,* confirmed by serum or urine protein electrophoresis or immunoelectrophoresis. Evaluate impairment under criteria for affected body system or under 7.02, 7.06, or 7.08.

7.15 *Chronic granulocytopenia (due to any cause).* With both A and B:

A. Absolute neutrophil counts repeatedly below 1,000 cells/cubic millimeter; and

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication.

7.16 *Myeloma (confirmed by appropriate serum or urine protein electrophoresis and bone marrow findings).*

With:

A. Radiologic evidence of bony involvement with intractable bone pain; or

B. Evidence of renal impairment as described in 6.02; or

C. Hypercalcemia with serum calcium levels persistently greater than 11 mg. per deciliter (100 ml.) for at least 1 month despite prescribed therapy; or

D. Plasma cells (100 or more cells/cubic millimeter) in the peripheral blood.

7.17 *Aplastic anemias or hematologic malignancies (excluding acute leukemia):* With bone marrow transplantation. Consider under a disability for 12 months following transplantation; thereafter, evaluate according to the primary characteristics of the residual impairment.

8.00 SKIN

A. *Skin lesions* may result in a marked, long-lasting impairment if they involve extensive body areas or critical areas such as the hands or feet and become resistant to treatment. These lesions must be shown to have persisted for a sufficient period of time despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months. The treatment for some of the skin diseases listed in this section may require the use of high dosage of drugs with possible serious side effects; these side effects should be considered in the overall evaluation of impairment.

B. *When skin lesions are associated with systemic disease* and where that is the predominant problems, evaluation should occur according to the criteria in the appropriate section. Disseminated (systemic) lupus erythematosus and scleroderma usually involve more than one body system and should be evaluated under 10.04 and 10.05. Neoplastic skin lesions should be evaluated under 13.00ff. When skin lesions (including burns) are associated with contractures or limitation of joint motion, that impairment should be evaluated under 1.00ff.

8.01 *Category of Impairments, Skin*

8.02 *Exfoliative dermatitis, ichthyosis, ichthyosiform erythroderma.* With extensive lesions not responding to prescribed treatment.

8.03 *Pemphigus, erythema multiforme bullosum, bullous pemphigoid, dermatitis herpetiformis.* With extensive lesions not responding to prescribed treatment.

8.04 *Deep mycotic infections.* With extensive fungating, ulcerating lesions not responding to prescribed treatment.

8.05 *Psoriasis, atopic dermatitis, dyshidrosis.* With extensive lesions, including involvement of the hands or feet which imposed a marked limitation of function and which are not responding to prescribed treatment.

8.06 *Hydradenitis suppurative, acne conglobata.* With extensive lesions involving the axillae or perineum not responding to prescribed medical treatment and not amenable to surgical treatment.

9.00 ENDOCRINE SYSTEM

Cause of impairment. Impairment is caused by overproduction or underproduction of hormones, resulting in structural or functional changes in the body. Where involvement of other organ systems has occurred as a result

of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

9.01 Category of Impairments, Endocrine

9.02 *Thyroid Disorders*. With:

A. Progressive exophthalmos as measured by exophthalmometry; or

B. Evaluate the resulting impairment under the criteria for the affected body system.

9.03 *Hyperparathyroidism*. With:

A. Generalized decalcification of bone on X-ray study and elevation of plasma calcium to 11 mg. per deciliter (100 ml.) or greater; or

B. A resulting impairment. Evaluate according to the criteria in the affected body system.

9.04 *Hypoparathyroidism*. With:

A. Severe recurrent tetany; or

B. Recurrent generalized convulsions; or

C. Lenticular cataracts. Evaluate under the criteria in 2.00ff.

9.05 *Neurohypophyseal insufficiency (diabetes insipidus)*. With urine specific gravity of 1.005 or below, persistent for at least 3 months and recurrent dehydration.

9.06 *Hyperfunction of the adrenal cortex*. Evaluate the resulting impairment under the criteria for the affected body system.

9.08 *Diabetes mellitus*. With:

A. Neuropathy demonstrated by significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C); or

B. Acidosis occurring at least on the average of once every 2 months documented by appropriate blood chemical tests (pH or pCO₂ or bicarbonate levels); or

C. Amputation at, or above, the tarsal region due to diabetic necrosis or peripheral arterial disease; or

D. Retinitis proliferans; evaluate the visual impairment under the criteria in 2.02, 2.03, or 2.04.

10.00 MULTIPLE BODY SYSTEMS

A. The impairments included in this section usually involve more than a single body system.

B. Long-term obesity will usually be associated with disorders in the musculoskeletal, cardiovascular, peripheral vascular, and pulmonary systems, and the advent of such disorders is the major cause of impairment. Extreme obesity results in restrictions imposed by body weight and the additional restrictions imposed by disturbances in other body systems.

10.01 Category of Impairments, Multiple Body Systems

10.02 *Hansen's disease (leprosy)*. As active disease or consider as "under a disability" while hospitalized.

10.03 *Polyarteritis or perarteritis nodosa (established by biopsy)*. With signs of generalized arterial involvement.

10.04 *Disseminated lupus erythematosus (established by a positive LE preparation or biopsy or positive ANA test)*. With frequent exacerbations demonstrating involvement of renal or cardiac or pulmonary or gastrointestinal or central nervous systems.

10.05 *Scleroderma or progressive systemic sclerosis (the diffuse or generalized form)*. With:

A. Advanced limitation of use of hands due to sclerodactylia or limitation in other joints; or

B. Significant visceral manifestations of digestive, cardiac, or pulmonary impairment.

10.10 *Obesity*. Weight equal to or greater than the values specified in Table I for males, Table II for females

(100 percent above desired level) and one of the following:

A. History of pain and limitation of motion in any weight bearing joint or spine (on physical examination) associated with X-ray evidence or arthritis in a weight bearing joint or spine; or

B. Hypertension with diastolic blood pressure persistently in excess of 100 mm. Hg measured with appropriate size cuff; or

C. History of congestive heart failure manifested by past evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema; or

D. Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or

E. Respiratory disease with total forced vital capacity equal to or less than 2.0 L. or a level of hypoxemia at rest equal to or less than the values specified in Table III-A or III-B or III-C.

Table I—Men

Height without shoes (inches) ¹	Weight (pounds)
60	246
61	252
62	258
63	264
64	270
65	276
66	284
67	294
68	302
69	310
70	318
71	328

Table I—Men—Continued

Height without shoes (inches) ¹	Weight (pounds)
72	336
73	346
74	356
75	364
76	374

Table II—Women

Height without shoes (inches) ¹	Weight (pounds)
56	208
57	212
58	218
59	224
60	230
61	236
62	242
63	250
64	258
65	266
66	274
67	282
68	290
69	298
70	306
71	314
72	322

Table III - A

[Applicable at test sites less than, 3,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

Table III - B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

Table III - C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO ₂ (mm. Hg) and	Arterial PO ₂ equal to or less than (mm. Hg)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

11.00 NEUROLOGICAL

A. *Convulsive disorders.* In convulsive disorders, regardless of etiology degree of impairment will be determined according to type, frequency, duration, and sequelae of seizures. At least one detailed description of a typical seizure is required. Such description includes the presence or absence of aura, tongue bites, sphincter control, injuries associated with the attack, and postictal phenomena. The reporting physician should indicate the extent to which description of seizures reflects his own observations and the source of ancillary information. Testimony of persons other than the claimant is essential for description of type and frequency of seizures if professional observation is not available.

Documentation of epilepsy should include at least one electroencephalogram (EEG).

Under 11.02 and 11.03, the criteria can be applied only if the impairment persists despite the fact that the individual is following prescribed anticonvulsive treatment. Adherence to prescribed anticonvulsive therapy can ordinarily be determined from objective clinical findings in the report of the physician currently providing treatment for epilepsy. Determination of blood levels of phenytoin sodium or other anticonvulsive drugs may serve to indicate whether the prescribed medication is being taken. When seizures are occurring at the frequency stated in 11.02 or 11.03, evaluation of the severity of the impairment must include consideration of the serum drug levels. Should serum drug levels appear therapeutically inadequate, consideration should be given as to whether this is caused by individual idiosyncrasy in absorption or metabolism of the drug. Blood drug levels should be evaluated in conjunction with all the other evidence to determine the extent of compliance. When the reported blood drug levels are low, therefore, the information obtained from the treating source should include the physician's statement as to why the levels are low and the results of any relevant diagnostic studies concerning the blood levels. Where adequate seizure control is obtained only with unusually large doses, the possibility of impairment resulting from the side effects of this medication must be also assessed. Where documentation shows that use of alcohol or drugs affects adherence to prescribed therapy or may play a part in the precipitation of seizures, this must also be considered in the overall assessment of impairment level.

B. Brain tumors. The diagnosis of malignant brain tumors must be established, and the persistence of the tumor should be evaluated, under the criteria described in 13.00B and C for neoplastic disease.

In histologically malignant tumors, the pathological diagnosis alone will be the decisive criterion for severity

and expected duration (see 11.05A). For other tumors of the brain, the severity and duration of the impairment will be determined on the basis of symptoms, signs, and pertinent laboratory findings (11.05B).

C. Persistent disorganization of motor function in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances (any or all of which may be due to cerebral, cerebellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combination, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of finger, hands, and arms.

D. In conditions which are episodic in character, such as multiple sclerosis or myasthenia gravis, consideration should be given to frequency and duration of exacerbations, length of remissions, and permanent residuals.

E. Multiple sclerosis. The major criteria for evaluating impairment caused by multiple sclerosis are discussed in listing 11.09. Paragraph A provides criteria for evaluating disorganization of motor function and gives reference to 11.04B (11.04B then refers to 11.00C). Paragraph B provides references to other listings for evaluating visual or mental impairments caused by multiple sclerosis. Paragraph C provides criteria for evaluating the impairment of individuals who do not have muscle weakness of other significant disorganization of motor function at rest, but who do develop muscle weakness on activity as a result of fatigue.

Use of the criteria in 11.09C is dependent upon (1) documenting a diagnosis of multiple sclerosis, (2) obtaining a description of fatigue considered to be characteristic of multiple sclerosis and (3) obtaining evidence that the system has actually become fatigued. The evaluation of

the magnitude of the impairment must consider the degree of exercise and the severity of the resulting muscle weakness.

The criteria in 11.09C deals with motor abnormalities which occur on activity. If the disorganization of motor function is present at rest, paragraph A must be used, taking into account any further increase in muscle weakness resulting from activity.

Sensory abnormalities may occur, particularly involving central visual acuity. The decrease in visual acuity may occur after brief attempts at activity involving near vision, such as reading. This decrease in visual acuity may not persist when the specific activity is terminated, as with rest, but is predictably reproduce with resumption of the activity. The impairment of central visual acuity in these cases should be evaluated under the criteria in listing 2.02, taking into account the fact that the decrease in visual acuity will wax and wane.

Clarification of the evidence regarding central nervous system dysfunction responsible for the symptoms may require supporting technical evidence of functional impairment such as evoked response tests during exercise.

11.01 Category of Impairments, Neurological

11.02 *Epilepsy—major motor seizures, (grand mal or psychomotor), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently the once a month, in spite of at least 3 months of prescribed treatment. With:*

A. Daytime episodes (loss of consciousness and convulsive seizures) or

B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.

11.03 *Epilepsy—Minor motor seizures (petit mal, psychomotor, or focal), documented by EEG and by*

detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestation of unconventional behavior or significant interference with activity during the day.

11.04 *Central nervous system vascular accident. With one of the following more than 3 months post-vascular accident:*

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.05 *Brain tumors.*

A. Malignant gliomas (astrocytoma—grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, or primary sarcoma; or

B. Astrocytoma (grades I and II), meningioma, pituitary tumors, oligodendroglioma, ependymoma, clivus chordoma, and benign tumors. Evaluate under 11.02, 11.03, 11.04A, or B, or 12.02.

11.06 *Parkinsonian syndrome* with the following signs: Significant rigidity, brady kinesia, or tremor in two extremities, which, singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station.

11.07 *Cerebral palsy, With:*

A. IQ of 69 or less; or

B. Abnormal behavior patterns, such as destructiveness or emotional instability; or

C. Significant interference in communication due to speech hearing, or visual defect; or

D. Disorganization of motor function as described in 11.04B.

11.08 *Spinal cord or nerve root lesions, due to any cause* with disorganization of motor function as described in 11.04B.

11.09 *multiple sclerosis*. With:

A. Disorganization of motor function as described in 11.04B; or

B. Visual or mental impairment as described under the criteria in 2.02, 2.03, 2.04, or 12.02; or

C. Significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process.

11.10 *Amyotrophic lateral sclerosis*. With:

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

11.011 *Anterior poliomyelitis*. With:

A. Persistent difficulty with swallowing or breathing; or

B. Unintelligible speech; or

C. Disorganization of motor function as described in 11.04B.

11.12 *Myasthenia gravis*. With:

A. Significant difficulty with speaking, swallowing, or breathing while on prescribed therapy; or

B. Significant motor weakness of muscles of extremities on repetitive activity against resistance while on prescribed therapy.

11.13 *Muscular dystrophy* with disorganization of motor function as described in 11.04B.

11.14 *Peripheral neuropathies*.

With disorganization of motor function as described in 11.04B, in spite of prescribed treatment.

11.15 *Tabes dorsalis*.

With:

A. Tabetic crises occurring more frequently than once monthly; or

B. Unsteady, broad-based or ataxic gait causing significant restriction of mobility substantiated by appropriate posterior column signs.

11.16 *Subacute combined cord degeneration (pernicious anemia) with disorganization of motor function as described in 11.04B or 11.15B, not significantly improved by prescribed treatment*.

11.17 *Degenerative disease not elsewhere such as Huntington's chorea, Friedreich's ataxia, and spino-cerebellar degeneration*.

With:

A. Disorganization of motor function as described in 11.04B or 11.15B; or

B. Chronic brain syndrome. Evaluate under 12.02.

11.18 *Cerebral trauma*:

Evaluate under the provisions of 11.02, 11.03, 11.04 and 12.02, as applicable.

11.19 *Syringomyelia*.

With:

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

12.00 MENTAL DISORDERS

The mental disorder listings in 12.00 of the Listing of Impairments will only be effective for 3 years unless extended by the Secretary or revised and promulgated again. Consequently, these listings will no longer be effective on August 28, 1988.

A. *Introduction:* The evaluation of disability on the basis of mental disorders requires the documentation of a medically determinable impairment(s) as well as consideration of the degree of limitation such impairment(s) may impose on the individual's ability to work and whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental disorders are arranged in eight diagnostic categories: organic mental disorders (12.02); schizophrenic, paranoid and other psychotic disorders (12.03); affective disorders (12.04); mental retardation and autism (12.05); anxiety related disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); and substance addiction disorders (12.09). Each diagnostic group, except listings 12.05 and 12.09, consists of a set of clinical findings (paragraph A criteria), one or more of which must be met, and which, if met, lead to a test of functional restrictions (paragraph B criteria), two or three of which must also be met. There are additional considerations (paragraph C criteria) in listings 12.03 and 12.06, discussed therein.

The purpose of including the criteria in paragraph A of the listings for mental disorders is to medically substantiate the presence of a mental disorder. Specific signs and symptoms under any of the listings 12.02 through 12.09 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) which is supported by the individual's clinical finding.

The purpose of including the criteria in paragraphs B and C of the listings for mental disorders is to describe those functional limitations associated with mental disorders which are incompatible with the ability to work. The restrictions listed in paragraphs B and C must be the result of the mental disorder which is manifested by the

clinical findings outlined in paragraph A. The criteria included in paragraphs B and C of the listings for mental disorders have been chosen because they represent functional areas deemed essential to work. An individual who is severely limited in these areas as the result of an impairment identified in paragraph A is presumed to be unable to work.

The structure of the listing for substance addiction disorders, listing 12.09, is different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances.

The listings for mental disorder are so constructed that an individual meeting or equaling the criteria could no reasonably be expected to engage in gainful work activity.

Individuals who have an impairment with a level of severity which does not meet the criteria of the listings for mental disorders may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful work activity. The determination of mental RFC is crucial to the evaluation of an individual's capacity to engage in substantial gainful work activity when the criteria of the listings for mental disorders are not met or equaled but the impairment is nevertheless severe.

RFC may be defined as a multidimensional description of the work-related abilities which an individual retains in spite of medical impairments. RFC complements the criteria in paragraphs B and C of the listings for mental disorders by requiring consideration of an expanded list of work-related capacities which may be impaired by mental disorder when the impairment is severe but does not meet or equal a listed mental disorder. (While RFC may be applicable in most claims, the law specifies that it does not

apply to the following special claims categories: disabled title XVI children below age 18, widows, widowers and surviving divorced wives. The impairment(s) of these categories must meet or equal a listed impairment for the individual to be eligible for benefits based on disability.)

B. Need for Medical Evidence: The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of clinical signs, symptoms and/or laboratory or psychological test findings. These findings may be intermittent or persistent depending on the nature of the disorder. Clinical signs are medically demonstrable phenomena which reflect specific abnormalities of behavior, affect, thought, memory, orientation, or contact with reality. These signs are typically assessed by a psychiatrist or psychologist and/or documented by psychological tests. Symptoms are complaints presented by the individual. Signs and symptoms generally cluster together to constitute recognizable clinical syndromes (mental disorders). Both symptoms and signs which are part of any diagnosed mental disorder must be considered in evaluating severity.

C. Assessment of Severity: For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph B of the listings for mental disorders (descriptions of restrictions of activities of daily living; social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work). Where "marked" is used as a standard for measuring the degree of limitation, it means more than moderate, but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function in-

dependently, appropriately and effectively. Four areas are considered.

1. *Activities of daily living* include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness and effectiveness. It is necessary to define the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

"Marked" is not the number of activities which are restricted but the overall degree of restriction or combination of restrictions which must be judged. For example, a person who is able to cook and clean might still have marked restrictions of daily activities if the person were too fearful to leave the immediate environment of home and neighborhood, hampering the person's ability to obtain treatment or to travel away from the immediate living environment.

2. *Social functioning* refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social functioning includes the ability to get along with others, e.g., family members, friends, neighbors, grocery clerks, landlords, bus drivers, etc. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Strength in social functioning may be documented by an individual's ability to initiate social contacts with others, communicate clearly with others, interact and actively participate in group activities, etc. Cooperative behaviors, consideration for others, awareness of others'

feelings, and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority, e.g., supervisors, or cooperative behaviors involving coworkers.

"Marked" is not the number of areas in which social functioning is impaired, but the overall degree of interference in a particular area or combination of areas of functioning. For example, a person who is highly antagonistic, uncooperative or hostile but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence and pace* refer to the ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete tasks in everyday household routines. Deficiencies in concentration, persistence and pace are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing, although mental status examination or psychological test data alone should not be used to accurately describe concentration and sustained ability to adequately perform work-like tasks. On mental status examinations, concentration is assessed by tasks such as having the individual subtract serial sevens from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits. In work evaluations, concentration, persistence, and pace are assessed through such tasks as filing index cards, locating telephone numbers, or disassembling and reassembling objects. Strengths and weak-

nesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task, and extent to which assistance is required to complete the task.

4. *Deterioration or decompensation in work or work-like settings* refers to repeated failure to adapt to stressful circumstances which cause the individual either to withdraw from that situation or to experience exacerbation of signs and symptoms (i.e., decompensation) with an accompanying difficulty in maintaining activities of daily living, social relationships, and/or maintaining concentration, persistence, or pace (i.e., deterioration which may include deterioration of adaptive behaviors). Stresses common to the work environment include decisions, attendance, schedules, completing tasks, interactions with supervisors, interactions with peers, etc.

D. *Documentation*: The presence of a mental disorder should be documented primarily on the basis of reports from individual providers, such as psychiatrists and psychologists, and facilities such as hospitals and clinics. Adequate descriptions of functional limitations must be obtained from these or other sources which may include programs and facilities where the individual has been observed over a considerable period of time.

Information from both medical and nonmedical sources may be used to obtain detailed descriptions of the individual's activities of daily living; social functioning; concentration, persistence and pace; or ability to tolerate increased mental demands (stress). This information can be provided by programs such as community mental health centers, day care centers, sheltered workshops, etc. It can also be provided by others, including family members, who have knowledge of the individual's functioning. In some cases descriptions of activities of daily living or social functioning given by individuals or treating sources

may be insufficiently detailed and/or may be in conflict with the clinical picture otherwise observed or described in the examinations or reports. It is necessary to resolve any inconsistencies or gaps that may exist in order to obtain a proper understanding of the individual's functional restrictions.

An individual's level of functioning may vary considerably over time. The level of functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of the impairment must take any variations in level of functioning into account in arriving at a determination of impairment severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior to the date of adjudication in order to establish the individual's impairment severity. This evidence should include treatment notes, hospital discharge summaries, and work evaluation or rehabilitation progress notes if these are available.

Some individuals may have attempted to work or may actually have worked during the period of time pertinent to the determination of disability. This may have been an independent attempt at work, or it may have been in conjunction with a community mental health or other sheltered program which may have been of either short or long duration. Information concerning the individual's behavior during any attempt to work and the circumstances surrounding termination of the work effort are particularly useful in determining the individual's ability or inability to function in a work setting.

The results of well-standardized psychological tests such as the Weschsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), the Rorschach, and the Thematic Apperception Test (TAT), may be useful in establishing the existence of a mental disorder. For example, the WAIS is useful in estab-

lishing the existence of a mental disorder. For example, the WAIS is useful in establishing mental retardation, and the MMPI, Rorschach, and TAT may provide data supporting several other diagnoses. Broad-based neuropsychological assessments using, for example, the Halstead-Reitan or the Luria-Nebraska batteries may be useful in determining brain function deficiencies, particularly in cases involving subtle findings such as may be seen in traumatic brain injury. In addition, the process of taking a standardized test requires concentration, persistence and pace; performance on such tests may provide useful data. Test results should, therefore, include both the objective data and a narrative description of clinical findings. Narrative reports of intellectual assessment should include a discussion of whether or not obtained IQ scores are considered valid and consistent with the individual's developmental history and degree of functional restriction.

In cases involving impaired intellectual functioning, a standardized intelligence test, e.g., the WAIS, should be administered and interpreted by a psychologist or psychiatrist qualified by training and experience to perform such an evaluation. In special circumstances, nonverbal measures, such as the Raven Progressive Matrices, the Leiter international scale, or the Arthur adaptation of the Leiter may be substituted.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 69 and below are characteristic of approximately the lowest 2 percent of the general population. In instances where other tests are administered, it would be necessary to convert the IQ to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by those IQ scores.

In cases where more than one IQ is customarily derived from the test administered, i.e., where verbal, performance, and full-scale IQs are provided as on the WAIS, the lowest of these is used in conjunction with listing 12.05.

In cases where the nature of the individual's intellectual impairment is such that standard intelligence tests, as described above, are precluded, medical reports specifically describing the level of intellectual, social, and physical function should be obtained. Actual observations by Social Security Administration or State agency personnel, reports from educational institutions and information furnished by public welfare agencies or other reliable objective sources should be considered as additional evidence.

E. *Chronic Mental Impairments:* Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Individuals with chronic psychotic disorders commonly have their lives structured in such a way as to minimize stress and reduce their signs and symptoms. Such individuals may be much more impaired for work than their signs and symptoms would indicate. The results of a single examination may not adequately describe these individuals' sustained ability to function. It is, therefore, vital to review all pertinent information relative to the individual's condition, especially at times of increased stress. It is mandatory to attempt to obtain adequate descriptive information from all sources which have treated the individual either currently or in the time period relevant to the decision.

F. *Effects of Structured Settings:* Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, board and care facility, or

other environment that provides similar structure. Highly structured and supportive settings may greatly reduce the mental demands placed on an individual. With lowered mental demands, overt signs and symptoms of the underlying mental disorder maybe minimized. At the same time, however, the individual's ability to function outside of such a structured and/or supportive setting may not have changed. An evaluation of individuals whose symptomatology is controlled or attenuated by psychosocial factors must consider the ability of the individual to function outside of such highly structured settings. (For these reasons the paragraph C criteria were added Listings 12.03 and 12.06.)

G. *Effects of Medication:* Attention must be given to the effect of medication on the individual's signs, symptoms and ability to function. While psychotropic medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychotropic medications, particular attention must be focused on the functional restrictions which may persist. These functional restrictions are also to be used as the measure of impairment severity. (See the paragraph C criteria in Listings 12.03 and 12.06.)

Neuroleptics, the medicines used in the treatment of some mental illnesses, may cause drowsiness, blunted affect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity. Where adverse effects of medications contribute to the impairment severity and the impairment does not meet or equal the listings but is nonetheless severe, such adverse effects must be considered in the assessment of the mental residual functional capacity.

H. *Effect of Treatment*: it must be remembered that with adequate treatment some individuals suffering with chronic mental disorders not only have their symptoms and signs ameliorated but also return to a level of function close to that of their premorbid status. Our discussion here in 12.00H has been designed to reflect the fact that present day treatment of a mentally impaired individual may or may not assist in the achievement of an adequate level of adaptation required in the work place. (See the paragraph C criteria in Listings 12.03 and 12.06.)

1. *Technique for Reviewing the Evidence in Mental Disorders Claims to Determine Level of Impairment Severity*: A special technique has been developed to ensure that all evidence needed for the evaluation of impairment severity in claims involving mental impairment is obtained, considered and properly evaluated. This technique, which is used in connection with the sequential evaluation process, is explained in § 404.1520a and § 416.920a.

12.01 Category of Impairments-Mental

12.02 *Organic Mental Disorders*: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or
2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (in-

ability to remember information that was known sometime in the past); or

3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or

4. Change in personality; or

5. Disturbance in mood; or

6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or

7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.03 *Schizophrenic, Paranoid and Other Psychotic Disorders*: Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or
2. Catatonic or other grossly disorganized behavior;

or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

- a. Blunt affect; or
- b. Flat affect; or
- c. Inappropriate affect;

or

4. Emotional withdrawal and/or isolation; AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Medically documented history of one or more episodes of acute symptoms, signs and functional limitations which at the time met the requirements in A and B of this listing, although these symptoms or signs are currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of deterioration or decompensation in situations which cause the individual to withdraw from that situation or to experience exacerbation of signs

or symptoms (which may include deterioration of adaptive behaviors); or

2. Documented current history of two or more years of inability to function outside of a highly supportive living situation.

12.04 *Affective Disorders*: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

- a. Anhedonia or pervasive loss of interest in almost all activities; or
- b. Appetite disturbance with change in weight; or
- c. Sleep disturbance; or
- d. Psychomotor agitation or retardation; or
- e. Decreased energy; or
- f. Feelings of guilt or worthlessness; or
- g. Difficulty concentrating or thinking; or
- h. Thoughts of suicide; or
- i. Hallucinations, delusions or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

- a. Hyperactivity; or
- b. Pressure of speech; or
- c. Flight of ideas; or
- d. Inflated self-esteem; or
- e. Decreased need for sleep; or
- f. Easy distractability; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized;
or

h. Hallucinations, delusions or paranoid thinking;
or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.05 Mental Retardation and Autism: Mental retardation refers to a significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22). (Note: The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.) Autism is a pervasive developmental disorder characterized by social and significant communication deficits originating in the developmental period.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded;

OR

B. A valid verbal, performance, or full scale IQ of 59 or less;

OR

C. A valid verbal, performance, or full scale IQ of 60 to 69 inclusive and a physical or other mental impairment imposing additional and significant work-related limitation of function;

OR

D. A valid verbal, performance, or full scale IQ of 60 to 69 inclusive or in the case of autism gross deficits of social and communicative skills with two of the following;

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.06 Anxiety Related Disorders: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation

in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

- a. Motor tension; or
- b. Autonomic hyperactivity; or
- c. Apprehensive expectation; or
- d. Vigilance and scanning;

or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

B. Resulting in at least two of the following:

- 1. Marked restriction of activities of daily living; or
- 2. Marked difficulties in maintaining social functioning; or
- 3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
- 4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the indi-

vidual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Resulting in complete inability to function independently outside the area of one's home.

12.07 *Somatoform Disorders*: Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or

2. Persistent nonorganic disturbance of one of the following:

- a. Vision; or
- b. Speech; or
- c. Hearing; or
- d. Use of a limb; or
- e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia; or
- f. Sensation (e.g., diminished or heightened).

3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury;

AND

B. Resulting in three of the following:

- 1. Marked restriction of activities of daily living; or
- 2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behavior).

12.08 Personality Disorders: A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:

1. Seclusiveness or autistic thinking; or
2. Pathologically inappropriate suspiciousness or hostility; or
3. Oddities of thought, perception, speech and behavior; or
4. Persistent disturbances of mood or affect; or
5. Pathological dependence, passivity, or aggressivity; or

6. Intense and unstable interpersonal relationships and impulsive and damaging behavior;

AND

- B. Resulting in three of the following:
1. Marked restriction of activities of daily living; or
 2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.09 Substance Addiction Disorders: Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

The required level of severity for these disorders is met when the requirements in any of the following (A through I) are satisfied.

- A. Organic mental disorders. Evaluate under 12.02.
- B. Depressive syndrome. Evaluate under 12.04.
- C. Anxiety disorders. Evaluate under 12.06.
- D. Personality disorders. Evaluate under 12.08.
- E. Peripheral neuropathies. Evaluate under 11.14.
- F. Liver damage. Evaluate under 5.05.
- G. Gastritis. Evaluate under 5.04.
- H. Pancreatitis. Evaluate under 5.08.
- I. Seizures. Evaluate under 11.02 or 11.03.

13.00 NEOPLASTIC DISEASES, MALIGNANT

A. *Introduction:* The determination of the level of impairment resulting from malignant tumors is made from a consideration of the site of the lesion, the histogenesis of the tumor, the extent of involvement, the apparent adequacy and response to therapy (surgery, irradiation, hormones, chemotherapy, etc.), and the magnitude of the post therapeutic residuals.

B. *Documentation:* The diagnosis of malignant tumors should be established on the basis of symptoms,

signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen. If these documents are not obtainable, then the summary of hospitalization or a report from the treating physician must include details of the findings at surgery and the results of the pathologist's gross and microscopic examination of the tissues.

For those cases in which a disabling impairment was not established when therapy was begun but progression of the disease is likely, current medical evidence should include a report of a recent examination directed especially at local or regional recurrence, soft part or skeletal metastases, and significant posttherapeutic residuals.

C. *Evaluation.* Usually, when the malignant tumor consists of a local lesion with metastases to the regional lymph nodes which apparently has been completely excised, imminent recurrence or metastases is not anticipated. A number of exceptions are noted in the specific Listings. For adjudicative purposes, "distant metastases" or "metastases beyond the regional lymph nodes" refers to metastasis beyond the lines of the usual radical en bloc resection.

Local or regional recurrence after radical surgery or pathological evidence of incomplete excision by radical surgery is to be equated with unresectable lesions (except for carcinoma of the breast, 13.09C) and, for the purposes of our program, may be evaluated as "inoperable."

Local or regional recurrence after incomplete excision of a localized and still completely resectable tumor is not to be equated with recurrence after radical surgery. In the evaluation of lymphomas, the tissue type and site of in-

volvement are not necessarily indicators of the degree of impairment.

When a malignant tumor has metastasized beyond the regional lymph nodes, the impairment will usually be found to meet the requirements of a specific listing. Exceptions are hormone-dependent tumors, isotope-sensitive metastases, and metastases from seminoma of the testicles which are controlled by definitive therapy.

When the original tumor and any metastases have apparently disappeared and have not been evident for 3 or more years, the impairment does not meet the criteria under this body system.

D. *Effects of therapy.* Significant posttherapeutic residuals, not specifically included in the category of impairments for malignant neoplasms, should be evaluated according to the affected body system.

Where the impairment is not listed in the Listing of Impairments and is not medically equivalent to a listed impairment, the impact of any residual impairment including that caused by therapy must be considered. The therapeutic regimen and consequent adverse response to therapy may vary widely; therefore, each case must be considered on an individual basis. It is essential to obtain a specific description of the therapeutic regimen, including the drugs given, dosage, frequency of drug administration, and plans for continued drug administration. It is necessary to obtain a description of the complications or any other adverse response to therapy such as nausea, vomiting, diarrhea, weakness, dermatologic disorders, or reactive mental disorders. Since the severity of the adverse effects of anticancer chemotherapy may change during the period of drug administration, the decision regarding the impact of drug therapy should be based on a sufficient period of therapy to permit proper consideration.

E. *Onset.* To establish onset of disability prior to the time a malignancy is first demonstrated to be inoperable or beyond control by other modes of therapy (and prior evidence is nonexistent) requires medical judgment based on medically reported symptoms, the type of the specific malignancy, its location, and extent of involvement when first demonstrated.

13.01 Category of Impairments, Neoplastic Diseases—Malignant

13.02 *Head and neck* (except salivary glands—13.07, thyroid gland—13.08, and mandible, maxilla, orbit, or temporal fossa—13.11):

- A. Inoperable; or
- B. Not controlled by prescribed therapy; or
- C. Recurrent after radical surgery or irradiation; or
- D. With distant metastases; or
- E. Epidermoid carcinoma occurring in the pyriform sinus or posterior third of the tongue.

13.03 *Sarcoma of skin:*

- A. Angiosarcoma with metastases to regional lymph nodes or beyond; or
- B. Mycosis fungoides with metastases to regional lymph nodes, or with visceral involvement.

13.04 *Sarcoma of soft parts:* Not controlled by prescribed therapy.

13.05 *Malignant melanoma:*

- A. Recurrent after wide excision; or
- B. With metastases to adjacent skin (satellite lesions) or elsewhere.

13.06 *Lymph nodes:*

A. Hodgkin's disease or non-Hodgkin's lymphoma with progressive disease not controlled by prescribed therapy; or

B. Metastatic carcinoma in a lymph node (except for epidermoid carcinoma in a lymph node in the neck) where

the primary site is not determined after adequate search; or

C. Epidermoid carcinoma in a lymph node in the neck not responding to prescribed therapy.

13.07 *Salivary glands*—carcinoma or sarcoma with metastases beyond the regional lymph nodes.

13.08 *Thyroid gland*—carcinoma with metastases beyond the regional lymph nodes, not controlled by prescribed therapy.

13.09 *Breast:*

- A. Inoperable carcinoma; or
- B. Inflammatory carcinoma; or
- C. Recurrent carcinoma, except local recurrence controlled by prescribed therapy; or
- D. Distant metastases from breast carcinoma (bilateral breast carcinoma, synchronous or metachronous is usually primary in each breast); or
- E. Sarcoma with metastases anywhere.

13.10 *Skeletal system* (exclusive of the jaw):

- A. Malignant primary tumors with evidence of metastases and not controlled by prescribed therapy; or
- B. Metastatic carcinoma to bone where the primary site is not determined after adequate search.

13.11 *Mandible, maxilla, orbit, or temporal fossa:*

- A. Sarcoma of any type with metastases; or
- B. Carcinoma of the antrum with extension into the orbit or ethmoid or sphenoid sinus, or with regional or distant metastases; or
- C. Orbital tumors with intracranial extension; or
- D. Tumors of the temporal fossa with perforation of skull and meningeal involvement; or
- E. Adamantinoma with orbital or intracranial infiltration; or
- F. Tumors of Rathke's pouch with infiltration of the base of the skull or metastases.

13.12 *Brain or spinal cord:*

- A. Metastatic carcinoma to brain to spinal cord.
- B. Evaluate other tumors under the criteria described in 11.05 and 11.08.

13.13 *Lungs.*

- A. Unresectable or with incomplete excision; or
- B. Recurrence or metastases after resection; or
- C. Oat cell (small cell) carcinoma; or
- D. Squamous cell carcinoma, with metastases beyond the hilar lymph nodes; or
- E. Other histologic types of carcinoma, including undifferentiated and mixed-cell types (but excluding oat cell carcinoma, 13.13C, and squamous cell carcinoma, 13.13D), with metastases to the hilar lymph nodes.

13.14 *Pleura or mediastinum:*

- A. Malignant mesothelioma of pleura; or
- B. Malignant tumors, metastatic to pleura; or
- C. Malignant primary tumor of the mediastinum not controlled by prescribed therapy.

13.15 *Abdomen:*

- A. Generalized carcinomatosis; or
- B. Retroperitoneal cellular sarcoma not controlled by prescribed therapy; or
- C. Ascites with demonstrated malignant cells.

13.16 *Esophagus or stomach:*

- A. Carcinoma or sarcoma of the esophagus; or
- B. Carcinoma of the stomach with metastases to the regional lymph nodes or extension to surrounding structure; or
- C. Sarcoma of stomach not controlled by prescribed therapy; or
- D. Inoperable carcinoma; or
- E. Recurrence or metastases after resection.

13.17 *Small intestine:*

- A. Carcinoma, sarcoma, or carcinoid tumor with metastases beyond the regional lymph nodes; or
- B. Recurrence of carcinoma, sarcoma, or carcinoid tumor after resection; or
- C. Sarcoma, not controlled by prescribed therapy.

13.18 *Large intestine (from ileocecal valve to and including anal canal)—carcinoma or sarcoma.*

- A. Unresectable; or
- B. Metastases beyond the regional lymph nodes; or
- C. Recurrence or metastases after resection.

13.19 *Liver or gallbladder:*

- A. Primary or metastatic malignant tumors of the liver; or
- B. Carcinoma of the gallbladder; or
- C. Carcinoma of the bile ducts.

13.20 *Pancreas:*

- A. Carcinoma except islet cell carcinoma; or
- B. Islet cell carcinoma which is unresectable and physiologically active.

13.21 *Kidneys, adrenal glands, or ureters—carcinoma:*

- A. Unresectable; or
- B. With hematogenous spread to distant sites; or
- C. With metastases to regional lymph nodes.

13.22 *Urinary bladder—carcinoma. With:*

- A. Infiltration beyond the bladder wall; or
- B. Metastases to regional lymph nodes; or
- C. Unresectable; or
- D. Recurrence after total cystectomy; or
- E. Evaluate renal impairment after total cystectomy under the criteria in 6.02.

13.23 *Prostate gland—carcinoma not controlled by prescribed therapy.*13.24 *Testicles:*

- A. Choriocarcinoma; or

B. Other malignant primary tumors with progressive disease not controlled by prescribed therapy.

13.25 *Uterus*—carcinoma or sarcoma (corpus or cervix).

A. Inoperable and not controlled by prescribed therapy; or

B. Recurrent after total hysterectomy; or

C. Total pelvic exenteration

13.26 *Ovaries*—all malignant, primary or recurrent tumors. With:

A. Ascites with demonstrated malignant cells; or

B. Unresectable infiltration; or

C. Unresectable metastases to omentum or elsewhere in the peritoneal cavity; or

D. Distant metastases.

13.27 *Leukemia*: Evaluate under the criteria of 7.00ff. Hemic and Lymphatic System [sic].

13.28 *Uterine (Fallopian) tubes*—carcinoma or sarcoma:

A. Unresectable, or

B. Metastases to regional lymph nodes.

13.29 *Penis*—carcinoma with metastases to regional lymph nodes.

13.30 *Vulva*—carcinoma, with distant metastases.

Part B

Medical criteria for the evaluation of impairments of children under age 18 (where criteria in Part A do not give appropriate consideration to the particular disease process in childhood).

Sec.

100.00 Growth Impairment.

101.00 Musculoskeletal System.

102.00 Special Senses and Speech.

103.00 Respiratory System.

104.00 Cardiovascular System.

105.00 Digestive System.

106.00 Genito-Urinary System.

107.00 Hemic and Lymphatic System.

108.00 [Reserved]

109.00 Endocrine System.

110.00 Multiple Body Systems.

111.00 Neurological.

112.00 Mental and Emotional Disorders.

113.00 Neoplastic Diseases, Malignant.

100.00 GROWTH IMPAIRMENT

A. *Impairment of growth* may be disabling in itself or it may be an indicator of the severity of the impairment due to a specific disease process.

Determinations of growth impairment should be based upon the comparison of current height with at least three previous determinations, including length at birth, if available. Heights (or lengths) should be plotted on a standard growth chart, such as derived from the National Center for Health Statistics: NCHS Growth Charts. Height should be measured without shoes. Body weight corresponding to the ages represented by the heights should be furnished. The adult heights of the child's natural parents and the heights and ages of siblings should also be furnished. This will provide a basis upon which to identify those children whose short stature represents a familial characteristic rather than a result of disease. This is particularly true for adjudication under 100.02B.

B. *Bone age determinations* should include a full descriptive report of roentgenograms specifically obtained to determine bone age and must cite the standardization method used. Where roentgenograms must be obtained

currently as a basis for adjudication under 100.03, views of the left hand and wrist should be ordered. In addition, roentgenograms of the knee and ankle should be obtained when cessation of growth is being evaluated in an older child at, or past, puberty.

C. The criteria in this section are applicable until closure of the major epiphyses. The cessation of significant increase in height at that point would prevent the application of these criteria.

100.01 Category of Impairments, Growth

100.02 *Growth impairment*, considered to be related to an additional specific medically determinable impairment, and one of the following:

A. Fall of greater than 15 percentiles in height which is sustained; or

B. Fall to, or persistence of, height below the third percentile.

100.03 *Growth impairment*, not identified as being related to an additional, specific medically determinable impairment. With:

A. Fall of greater than 25 percentiles in height which is sustained; and

B. Bone age greater than two standard deviations (2 SD) below the mean for chronological age (see 100.00B).

101.00 MUSCULOSKELETAL SYSTEM

A. *Rheumatoid arthritis*. Documentation of the diagnosis of juvenile rheumatoid arthritis should be made according to an established protocol, such as that published by the Arthritis Foundation, *Bulletin on the Rheumatic Diseases*. Vol. 23, 1972-1973 Series, p 712. Inflammatory signs include persistent pain, tenderness, erythema, swelling, and increased local temperature of a joint.

B. *The measurements of joint motion* are based on the technique for measurements described in the "Joint Method of Measuring and Recording." [sic] published by the American Academy of Orthopedic Surgeons in 1965, or "The Extremities and Back" in *Guides to the Evaluation of Permanent Impairment*, Chicago, American Medical Association, 1971, Chapter 1, pp. 1-48.

C. *Degenerative arthritis* may be the end stage of many skeletal diseases and conditions, such as traumatic arthritis, congenital dislocation of the hip, aseptic necrosis of the hip, slipped capital femoral epiphyses, skeletal dysplasias, etc.

101.02 Category of Impairments, Musculoskeletal

101.02 *Juvenile rheumatoid arthritis*. With:

A. Persistence or recurrence of joint inflammation despite three months of medical treatment and one of the following:

1. Limitation of motion of two major joints of 50 percent or greater; or

2. Fixed deformity of two major weight-bearing joints of 30 degrees or more; or

3. Radiographic changes of joint narrowing, erosion, or subluxation; or

4. Persistent or recurrent systemic involvement such as iridocyclitis or pericarditis; or

B. Steroid dependence.

101.03 *Deficit of musculoskeletal function* due to deformity or musculoskeletal disease and one of the following:

A. Walking is markedly reduced in speed or distance despite orthotic or prosthetic devices; or

B. Ambulation is possible only with obligatory bilateral upper limb assistance (e.g., with walker, crutches); or

C. Inability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene.

101.05 *Disorders of the spine.*

A. Fracture of vertebra with cord involvement (substantiated by appropriate sensory and motor loss); or

B. Scoliosis (congenital idiopathic or neuromyopathic). With:

1. Major spinal curve measure 60 degrees or greater; or

2. Spinal fusion of six or more levels. Consider under a disability for one year from the time of surgery; thereafter evaluate the residual impairment; or

3. FEV (vital capacity) of 50 percent or less of predicted normal values for the individual's measured (actual) height; or

C. Kyphosis or lordosis measuring 90 degrees or greater.

101.08 *Chronic osteomyelitis* with persistence or recurrence of inflammatory signs or drainage for at least 6 months despite prescribed therapy and consistent radiographic findings.

102.00 SPECIAL SENSES AND SPEECH

A. *Visual impairments in children.* Impairment of central visual acuity should be determined with use of the standard Snellen test chart. Where this cannot be used, as in very young children, a complete description should be provided of the findings using other appropriate methods of examination, including a description of the techniques used for determining the central visual acuity for distance.

The accommodative reflex is generally not present in children under 6 months of age. In premature infants, it may not be present until 6 months plus the number of months the child is premature. Therefore absence of accommodative reflex will be considered as indicating a visual impairment only in children above this age (6 months).

Documentation of a visual disorder must include description of the ocular pathology.

B. *Hearing impairments in children.* The criteria for hearing impairments in children take into account that a lesser impairment in hearing which occurs at an early age may result in a severe speech and language disorder.

Improvement by a hearing aid, as predicted by the testing procedure, must be demonstrated to be feasible in that child, since younger children may be unable to use a hearing aid effectively.

The type of audiometric testing performed must be described and a copy of the results must be included. The pure tone air conduction hearing levels in 102.08 are based on American National Standard Institute Specifications for Audiometers, S3.6-1969 (ANSI-1969). The report should indicate the specifications used to calibrate the audiometer.

The finding of a severe impairment will be based on the average hearing levels at 500, 1000, 2000, and 3000 Hertz (Hz) in the better ear, and on speech discrimination, as specified in § 102.08.

102.01 Category of Impairments, Special Sense Organs

102.02 *Impairments of central visual acuity.*

A. Remaining vision in the better eye after best correction is 20/200 or less; or

B. For children below 3 years of age at time of adjudication:

1. Absence of accommodative reflex (see 102.00A for exclusion of children under 6 months of age); or

2. Retrolental fibroplasia with macular scarring or neovascularization; or

3. Bilateral congenital cataracts with visualization of retinal red reflex only or when associated with other ocular pathology.

102.08 *Hearing impairments.*

A. For children below 5 years of age at time of adjudication, inability to hear air conduction thresholds at an average of 40 decibels (db) hearing level or greater in the better ear; or

B. For children 5 years of age and above at time of adjudication:

1. Inability to hear air conduction thresholds at an average of 70 decibels (db) or greater in the better ear; or

2. Speech discrimination scores at 40 percent or less in the better ear; or

3. Inability to hear air conduction thresholds at an average of 40 decibels (db) or greater in the better ear, and a speech and language disorder which significantly affects the clarity and content of the speech and is attributable to the hearing impairment.

103.00 RESPIRATORY SYSTEM

A. *Documentation of pulmonary insufficiency.* The reports of spirometric studies for evaluation under Table I must be expressed in liters (BTPS). The reported FEV₁ should represent the largest of at least three satisfactory attempts. The appropriately labeled spirometric tracing of three FEV maneuvers must be submitted with the report, showing distance per second on the abscissa and distance per liter on the ordinate. The unit distance for volume on the tracing should be at least 15 mm. per liter and the paper speed at least 20 mm. per second. The height of the individual without shoes must be recorded.

The ventilatory function studies should not be performed during or soon after an acute episode or exacerbation of a respiratory illness. In the presence of acute bronchospasm, or where the FEV₁ is less than that stated in Table I, the studies should be repeated after the admini-

stration of a nebulized bronchodilator. If a bronchodilator was not used in such instances, the reason should be stated in the report.

A statement should be made as to the child's ability to understand directions and to cooperate in performance of the test, and should include an evaluation of the child's effort. When tests cannot be performed or completed, the reason (such as a child's young age) should be stated in the report.

B. *Cystic fibrosis.* This section discusses only the pulmonary manifestations of cystic fibrosis. Other manifestations, complications, or associated disease must be evaluated under the appropriate section.

The diagnosis of cystic fibrosis will be based upon appropriate history, physical examination, and pertinent laboratory findings. Confirmation based upon elevated concentration of sodium or chloride in the sweat should be included, with indication of the technique used for collection and analysis.

103.01 *Category of Impairments, Respiratory.*

103.03 *Bronchial asthma.* With evidence of progression of the disease despite therapy and documented by one of the following:

A. Recent, recurrent intense asthmatic attacks requiring parenteral medication; or

B. Persistent prolonged expiration with wheezing between acute attacks and radiographic findings of peribronchial disease.

103.13 *Pulmonary manifestations of cystic fibrosis.* With:

A. FEV₁ equal to or less than the values specified in Table I (see § 103.00A for requirements of ventilatory function testing); or

B. For children where ventilatory function testing cannot be performed:

1. History of dyspnea on mild exertion or chronic frequent productive cough; and
2. Persistent or recurrent abnormal breath sounds, bilateral rales or rhonchi; and
3. Radiographic findings of extensive disease with hyperaeration and bilateral peribronchial infiltration.

Table I

Height (in centimeters)	FEV ₁ equal to or less than (L, BTPS)
110 or less	0.6
120	0.7
130	0.9
140	1.1
150	1.3
160	1.5
170 or more	1.6

104.00 CARDIOVASCULAR SYSTEM

A. *General.* Evaluation should be based upon history, physical findings, and appropriate laboratory data. Reported abnormalities should be consistent with the pathologic diagnosis. The actual electrocardiographic tracing, or an adequate marked photocopy, must be included. Reports of other pertinent studies necessary to substantiate the diagnosis or describe the severity of the impairment must also be included:

B. *Evaluation of cardiovascular impairment in children* requires two steps:

1. The delineation of a specific cardiovascular disturbance, either congenital or or [sic] acquired. This may include arterial or venous disease, rhythm disturbance, or

disease involving the valves, septa, myocardium or pericardium; and

2. Documentation of the severity of the impairment, with medically determinable and consistent cardiovascular signs, symptoms, and laboratory data. In cases where impairment characteristics are questionably secondary to the cardiovascular disturbance, additional documentation of the severity of the impairment (e.g., catheterization data, if performed) will be necessary.

C. *Chest roentgenogram* (6 ft. PA film) will be considered indicative of cardiomegaly if:

1. The cardiothoracic ratio is over 60 percent at age one year or less, or 55 percent at more than one year of age; or
2. The cardiac size is increased over 15 percent from any prior chest roentgenograms; or
3. Specific chamber or vessel enlargement is documented in accordance with established criteria.

D. *Tables I, II and III* below are designed for case adjudication and not for diagnostic purposes. The adult criteria may be useful for older children and should be used when applicable.

E. *Rheumatic fever*, as used in this section assumes diagnosis made according to the revised Jones Criteria.

104.01 Category of Impairments, Cardiovascular

104.02 *Chronic congestive failure.* With two or more of the following signs:

- A. Tachycardia (see Table I).
- B. Tachypnea (see Table II).
- C. Cardiomegaly on chest roentgenogram (see 104.00C).
- D. Hepatomegaly (more than 2 cm. below the right costal margin in the right midclavicular line).
- E. Evidence of pulmonary edema, such as rales or orthopnea.

F. Dependent edema.

G. Exercise intolerance manifested as labored respiration on mild exertion (e.g., in an infant, feeding).

TABLE I—TACHYCARDIA AT REST

Age	Apical Heart (beats per minute)
Under 1 yr	150
1 through 3 yrs	130
4 through 9 yrs	120
10 through 15 yrs	110
Over 15 yr	100

TABLE II—TACHYPNEA AT REST

Age	Respiratory rate over (per minute)
Under 1 yr	40
1 through 5 yrs	35
6 through 9 yrs	30
Over 9 yrs	25

104.03 *Hypertensive cardiovascular disease.* With persistently elevated blood pressure for age (see Table III) and one of the following:

A. Impaired renal function as described under the criteria in 106.02; or

B. Cerebrovascular damage as described under the criteria in 111.06; or

C. Congestive heart failure as described under the criteria in 104.02.

TABLE III—ELEVATED BLOOD PRESSURE

Age	S (over) mm.	Diastolic (over) in mm.
Under 6 mo	95	60
6 mo. to 1 yr	110	70
1 through 8 yrs	115	80
9 through 11 yrs	120	80
12 through 15 yrs	130	80
Over 15 yrs.	140	80

104.04 *Cyanotic congenital heart disease.*

With one of the following:

A. Surgery is limited to palliative measures; or

B. Characteristic squatting, hemoptysis, syncope, or hypercyanotic spells; or

C. Chronic hematocrit of 55 percent of greater or arterial O₂ saturation of less than 90 percent at rest, or arterial oxygen tension of less than 60 Torr at rest.

104.05 *Cardiac arrhythmia, such as persistent or recurrent heart block or A-V dissociation (with or without therapy).* And one of the following:

A. Cardiac syncope; or

B. Congestive heart failure as described under the criteria in 104.02; or

C. Exercise intolerance with labored respirations on mild exertion (e.g., in infants, feeding).

104.07 *Cardiac syncope* with at least one documented syncopal episode characteristic of specific cardiac disease (e.g., aortic stenosis).

104.08 *Recurrent hemoptysis.* Associated with either pulmonary hypertension or extensive bronchial collaterals due to documented chronic cardiovascular disease.

104.09 *Chronic rheumatic fever or rheumatic heart disease.* With:

A. Persistence of rheumatic fever activity for 6 months or more, with significant murmur(s), cardiomegaly (see 104.00C), and other abnormal laboratory findings (such as elevated sedimentation rate or electrocardiographic findings); or

B. Congestive heart failure as described under the criteria in 104.02.

105.00 DIGESTIVE SYSTEM

A. *Disorders of the digestive system* which result in disability usually do so because of interference with nutrition and growth, multiple recurrent inflammatory lesions, or other complications of the disease. Such lesions or complications usually respond to treatment. To constitute a listed impairment, these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Documentation of gastrointestinal impairments* should include pertinent operative findings, radiographic studies, endoscopy, and biopsy reports. Where a liver biopsy has been performed in chronic liver disease, documentation should include the report of the biopsy.

C. *Growth retardation and malnutrition.* When the primary disorder of the digestive tract has been documented, evaluate resultant malnutrition under the criteria described in 105.08. Evaluate resultant growth impairment under the criteria described in 100.03. Intestinal disorders, including surgical diversions and potentially correctable congenital lesions, do not represent a severe impairment if the individual is able to maintain adequate nutrition growth and development.

D. *Multiple congenital anomalies.* See related criteria, and consider as a combination of impairments.

105.01 *Category of Impairments.* Digestive

105.03 *Esophageal obstruction, caused by atresia, stricture, or stenosis* with malnutrition as described under the criteria in 105.08.

105.05 *Chronic liver disease.* With one of the following:

A. Inoperable biliary atresia demonstrated by X-ray or surgery; or

B. Intractable ascites not attributable to other causes, with serum albumin of 3.0 gm./100 ml. or less; or

C. Esophageal varices (demonstrated by angiography, barium swallow, or endoscopy or by prior performance of a specific shunt or plication procedure); or

D. Hepatic coma documented by findings from hospital records; or

E. Hepatic encephalopathy. Evaluate under the criteria in 112.02; or

F. Chronic active inflammation or necrosis documented by SGOT persistently more than 100 units or serum bilirubin of 2.5 mg. percent or greater.

105.07 *Chronic inflammatory bowel disease (such as ulcerative colitis, regional enteritis), as documented in 105.00.* With one of the following:

A. Intestinal manifestations or complications, such as obstruction, abscess, or fistula formation which has lasted or is expected to last 12 months; or

B. Malnutrition as described under the criteria in 105.08; or

C. Growth impairment as described under the criteria in 100.03.

105.08 *Malnutrition, due to demonstrable gastrointestinal disease causing either a fall of 15 percentiles of weight which persist or the persistence of weight*

which is less than the third percentile (on standard growth charts). And one of the following:

- A. Stool fat excretion per 24 hours:
 - 1. More than 15 percent in infants less than 6 months.
 - 2. More than 10 percent in infants 6-18 months.
 - 3. More than 6 percent in children more than 18 months; or
- B. Persistent hematocrit of 30 percent or less despite prescribed therapy; or
- C. Serum carotene of 40 mcg./100 ml. or less; or
- D. Serum albumin of 3.0 gm./100 ml. or less.

106.00 GENITO-URINARY SYSTEM

A. *Determination of the presence of chronic renal disease* will be based upon the following factors:

- 1. History, physical examination, and laboratory evidence of renal disease.
- 2. Indications of its progressive nature or laboratory evidence of deterioration of renal function.

B. *Renal transplant.* The amount of function restored and the time required to effect improvement depend upon various factors including adequacy of post transplant renal function, incidence of renal infection, occurrence of rejection crisis, presence of systemic complications (anemia, neuropathy, etc.) and side effects of corticosteroid or immuno-suppressive agents. A period of at least 12 months is required for the individual to reach a point of stable medical improvement.

C. Evaluate associated disorders and complications according to the appropriate body system listing.

106.01 Category of Impairments, Genito-Urinary.

106.02 *Chronic renal disease.* With:

A. Persistent elevation of serum creatinine to 3 mg. per deciliter (100 ml.) or greater over at least 3 months; or

B. Reduction of creatinine clearance to 30 ml. per minute (43 liters/24 hours) per 1.73m² of body surface area over at least 3 months; or

C. Chronic renal dialysis program for irreversible renal failure; or

D. Renal transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 106.00B).

106.06 Nephrotic syndrome, with edema not controlled by prescribed therapy. And:

- A. Serum albumin less than 2 gm./100 ml.; or
- B. Proteinuria more than 2.5 gm./1.73m²/day.

107.00 HEMIC AND LYMPHATIC SYSTEM

A. *Sickle cell disease* refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell diseases, such as hemoglobin electrophoresis must be included. Vaso-occlusive, hemolytic, or aplastic episodes should be documented by description of severity, frequency, and duration.

Disability due to sickle cell disease may be solely the result of a severe, persistent anemia or may be due to the combination of chronic progressive or episodic manifestations in the presence of a less severe anemia.

Major visceral episodes causing disability include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genitourinary involvement, etc.

B. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory

evidence such as abnormal thromboplastin generation, coagulation time, or factor assay.

C. *Acute leukemia*. Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The designated duration of disability implicit in the finding of a listed impairment is contained in 107.11. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of any remaining impairment must be evaluated on the basis of the medical evidence.

107.01 Category of Impairments, Hemic and Lymphatic

107.03 *Hemolytic anemia (due to any cause)*. Manifested by persistence of hematocrit of 26 percent or less despite prescribed therapy, reticulocyte count of 4 percent or greater.

107.05 *Sickle cell disease*. With:

A. Recent, recurrent, severe vaso-occlusive crises (musculoskeletal, vertebral, abdominal); or

B. A major visceral complication in the 12 months prior to application; or

C. A hyperhemolytic or aplastic crisis within 12 months prior to application; or

D. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

E. Congestive heart failure, cerebrovascular damage, or emotional disorder as described under the criteria in 104.02, 111.00ff, or 112.00ff.

107.06 *Chronic idiopathic thrombocytopenic purpura of childhood* with purpura and thrombocytopenia of 40,000 platelets/cu. mm. or less despite prescribed therapy or recurrent upon withdrawal of treatment.

107.08 *Inherited coagulation disorder*.

With:

A. Repeated spontaneous in inappropriate bleeding; or

B. Hemarthrosis with joint deformity.

107.11 *Acute leukemia*. Consider under a disability:

A. For 2½ years from the time of initial diagnosis; or

B. For 2½ years from the time of recurrence of active disease.

108.00 [RESERVED]

109.00 ENDOCRINE SYSTEM

A. *Cause of disability*. Disability is caused by a disturbance in the regulation of the secretion or metabolism of one or more hormones which are not adequately controlled by therapy. Such disturbances or abnormalities usually respond to treatment. To constitute a listed impairment these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Growth*. Normal growth is usually a sensitive indicator of health as well as of adequate therapy in children. Impairment of growth may be disabling in itself or may be an indicator of a severe disorder involving the endocrine system or other body systems. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

C. *Documentation*. Description of characteristic history, physical findings, and diagnostic laboratory data must be included. Results of laboratory tests will be considered abnormal if outside the normal range or greater than two standard deviations from the mean of the testing

laboratory. Reports in the file should contain the information provided by the testing laboratory as to their normal values for that test.

D. *Hyperfunction of the adrenal cortex.* Evidence of growth retardation must be documented as described in 100.00. Elevated blood or urinary free cortisol levels are not acceptable in lieu of urinary 17-hydroxycorticosteroid excretion for the diagnosis of adrenal cortical hyperfunction.

E. *Adrenal cortical insufficiency.* Documentation must include persistent low plasma cortisol or low urinary 17-hydroxycorticosteroids or 17-ketogenic steroids and evidence of unresponsiveness to ACTH stimulation.

109.01 Category of Impairments, Endocrine [sic]

109.02 *Thyroid Disorders.*

A. *Hyperthyroidism* (as documented in 109.00C). With clinical manifestations despite prescribed therapy, and one of the following:

1. Elevated serum thyroxine (T_4) and either elevated free T_4 or resin T_3 uptake; or
2. Elevated thyroid uptake of radioiodine; or
3. Elevated serum triiodothyronine (T_3).

B. *Hypothyroidism.* With one of the following, despite prescribed therapy:

1. IQ of 69 or less; or
2. Growth impairment as described under the criteria in 100.02 A and B; or
3. Precocious puberty.

109.03 *Hyperparathyroidism* (as documented in 109.00C). With:

A. Repeated elevated total or ionized serum calcium; or

B. Elevated serum parathyroid hormone.

109.04 *Hypoparathyroidism or Pseudohypoparathyroidism.* With:

A. Severe recurrent tetany or convulsions which are unresponsive to prescribed therapy; or

B. Growth retardation as described under criteria in 100.02 A and B.

109.05 *Diabetes insipidus, documented by pathologic hypertonic saline or water deprivation test.* And one of the following:

A. Intracranial space-occupying lesion, before or after surgery; or

B. Unresponsiveness to Pitressin; or

C. Growth retardation as described under the criteria in 100.02 A and B; or

D. Unresponsive hypothalamic thirst center, with chronic or recurrent hypernatremia; or

E. Decreased visual fields attributable to a pituitary lesion.

109.06 *Hyperfunction of the adrenal cortex (Primary or secondary).* With:

A. Elevated urinary 17-hydroxycortico-steroids (or 17-ketogenic steroids) as documented in 109.00 C and D; and

B. Unresponsiveness to low-dose dexamethasone suppression.

109.07 *Adrenal cortical insufficiency* (as documented in 109.00 C and E) with recent, recurrent episodes of circulatory collapse.

109.08 *Juvenile diabetes mellitus* (as documented in 109.00C) requiring parenteral insulin. And one of the following, despite prescribed therapy:

A. Recent, recurrent hospitalizations with acidosis; or

B. Recent, recurrent episodes of hypoglycemia; or

C. Growth retardation as described under the criteria in 100.02 A or B; or

D. Impaired renal function as described under the criteria in 106.00ff.

109.09 *Iatrogenic hypercorticot state.*

With chronic glucocorticoid therapy resulting in one of the following:

- A. Osteoporosis; or
- B. Growth retardation as described under the criteria in 100.02 A or B; or
- C. Diabetes mellitus as described under the criteria in 109.08; or
- D. Myopathy as described under the criteria in 111.06; or
- E. Emotional disorder as described under the criteria in 112.00ff.

109.10 *Pituitary dwarfism (with documented growth hormone deficiency).* And growth impairment as described under the criteria in 100.02B.

109.11 *Adrenogenital syndrome.* With:

- A. Recent, recurrent self-losing episodes despite prescribed therapy; or
- B. Inadequate replacement therapy manifested by accelerated bone age and virilization, or
- C. Growth impairment as described under the criteria in 100.02 A or B.

109.12 *Hypoglycemia (as documented in 109.00C).* With recent, recurrent hypoglycemic episodes producing convulsion or coma.

109.13 *Gonadal Dysgenesis (Turner's Syndrome), chromosomally proven.* Evaluate the resulting impairment under the criteria for the appropriate body system.

110.00 MULTIPLE BODY SYSTEMS

A. *Catastrophic congenital abnormalities or disease.* This section refers only to very serious congenital disorders, diagnosed in the newborn or infant child.

B. *Immune deficiency diseases.* Documentation of immune deficiency disease must be submitted, and may in-

clude quantitative immunoglobulins, skin tests for delayed hypersensitivity, lymphocyte stimulative tests, and measurements of cellular immunity mediators.

110.01 Category of Impairments, Multiple Body Systems

110.08 *Catastrophic congenital abnormalities or disease.* With:

- A. A positive diagnosis (such as anencephaly, trisomy D or E, cyclopia, etc.), generally regarded as being incompatible with extrauterine life; or
- B. A positive diagnosis (such as cri du chat, Tay-Sachs Disease) wherein attainment of the growth and development level of 2 years is not expected to occur.

110.09 *Immune deficiency disease.*

A. *Hypogammaglobulinemia or dysgammaglobulinemia.* With:

- 1. Recent, recurrent severe infections; or
- 2. A complication such as growth retardation, chronic lung disease, collagen disorder, or tumors.

E. *Thymic dysplastic syndromes* (such as Swiss, diGeorge).

111.00 NEUROLOGICAL

A. *Seizure disorder* must be substantiated by at least one detailed description of a typical seizure. Report of recent documentation should include an electroencephalogram and neurological examination. Sleep EEG is preferable, especially with temporal lobe seizures. Frequently of attacks and any associated phenomena should also be substantiated.

Young children may have convulsions in association with febrile illnesses. Proper use of 111.02 and 111.03 requires that a seizure disorder be established. Although this does not exclude consideration of seizures occurring dur-

ing febrile illnesses, it does require documentation of seizures during nonfebrile periods.

There is an expected delay in control of seizures when treatment is started, particularly when changes in the treatment regimen are necessary. Therefore, a seizure disorder should not be considered to meet the requirements of 111.02 or 111.03 unless it is shown that seizure have persisted more than three months after prescribed therapy began.

B. *Minor motor seizures.* Classical petit mal seizures must be documented by characteristic EEG pattern, plus information as to age at onset and frequency of clinical seizures. Myoclonic seizures, whether of the typical infantile or Lennox-gastaut variety after infancy, must also be documented by the characteristic EEG pattern plus information as to age at onset and frequency of seizures.

C. *Motor dysfunction.* As described in 111.06, motor dysfunction may be due to any neurological disorder. It may be due to static or progressive conditions involving any area of the nervous system and producing any type of neurological impairment. This may include weakness, spasticity, lack of coordination, ataxia, tremor, athetosis, or sensory loss. Documentation of motor dysfunction must include neurologic findings and description of type of neurological abnormality (e.g., spasticity, weakness), as well as a description of the child's functional impairment (i.e., what the child is unable to do because of the abnormality). Where a diagnosis has been made, evidence should be included for substantiation of the diagnosis (e.g., blood chemistries and muscle biopsy reports), whenever applicable.

D. *Impairment of communications.* The documentation should include a description of a recent comprehensive evaluation, including all areas of affective and effec-

tive communication, performed by a qualified professional.

111.01 Category of Impairment, Neurological

111.02 *Major motor seizure disorder.*

A. *Major motor seizures.* In a child with an established seizure disorder, the occurrence of more than one major motor seizure per month despite at least three months of prescribed treatment. With:

1. Daytime episodes (loss of consciousness and convulsive seizures); or
2. Nocturnal episodes manifesting residuals which interfere with activity during the day.

B. *Major motor seizures.* In a child with an established seizure disorder, the occurrence of a [sic] least one major motor seizure in the year prior to application despite at least three months of prescribed treatment. And one of the following:

1. IQ of 69 or less; or
2. Significant interference with communication due to speech, hearing, or visual defect; or
3. Significant emotional disorder; or
4. Where significant adverse effects of medication interfere with major daily activities.

111.03 *Minor motor seizure disorder.* In a child with an established seizure disorder, the occurrence of more than one minor motor seizure per week, with alteration of awareness or loss of consciousness, despite at least three months of prescribed treatment.

111.05 *Brain tumors.* A. *Malignant gliomas* (astrocytoma—Grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, primary sarcoma or brain stem gliomas; or

B. Evaluate other brain tumors under the criteria for the resulting neurological impairment.

111.06 *Motor dysfunction (due to any neurological disorder)*. Persistent disorganization or deficit of motor function for age involving two extremities, which (despite prescribed therapy) interferes with age-appropriate major daily activities and results in disruption of:

- A. Fine and gross movements; or
- B. Gait and station.

111.07 *Cerebral palsy*. With:

- A. Motor dysfunction meeting the requirements of 111.06 or 101.03; or
- B. Less severe motor dysfunction (but more than slight) and one of the following:
 - 1. IQ of 69 or less; or
 - 2. Seizure disorder, with at least one major motor seizure in the year prior to application; or
 - 3. Significant interference with communication due to speech, hearing or visual defect; or
 - 4. Significant emotional disorder.

111.08 *Meningomyelocele (and related disorders)*. with one of the following despite prescribed treatment:

- A. Motor dysfunction meeting the requirements of § 101.03 or § 111.06; or
- B. Less severe motor dysfunction (but more than slight), and:
 - 1. Urinary or fecal incontinence when inappropriate for age; or
 - 2. IQ of 69 or less; or
- C. Four extremity involvement; or
- D. Noncompensated hydrocephalus producing interference with mental or motor developmental progression.

111.09 *Communication impairment, associated with documented neurological disorder*. And one of the following:

- A. Documented speech deficit which significantly affects the clarity and content of the speech; or
- B. Documented comprehension deficit resulting in ineffective verbal communication for age; or
- C. Impairment of hearing as described under the criteria in 102.08.

112.00 MENTAL AND EMOTIONAL DISORDERS

A. *Introduction*. This section is intended primarily to describe mental and emotional disorders of young children. The criteria describing mentally determinable impairments in adults should be used where they clearly appear to be more appropriate.

B. *Mental retardation. General*. As with any other impairment, the necessary evidence consists of symptoms, signs, and laboratory findings which provide medically demonstrable evidence of impairment severity. Standardized intelligence test results are essential to the adjudication of all cases of mental retardation that are not clearly covered under the provisions of 112.05 A. Developmental milestone criteria may be the sole basis for adjudication only in cases where the child's young age and/or condition preclude formal standardized testing by a psychologist or psychiatrist experienced in testing children.

Measures of intellectual functioning. Standardized intelligence tests, such as the Wechsler Preschool and Primary Scale of Intelligence (WPPSI), the Wechsler Intelligence Scale for Children—Revised (WISC-R), the Revised Stanford-Binet Scale, and the McCarthy Scales of Children's Abilities, should be used wherever possible. Key data such as subtest scores should also be included in the report. Tests should be administered by a qualified and experienced psychologist or psychiatrist, and any discrepancies between formal test results and the child's

customary behavior and daily activities should be duly noted and resolved.

Developmental milestone criteria. In the event that a child's young age and/or condition preclude formal testing by a psychologist or psychiatrist experienced in testing children, a comprehensive evaluation covering the full range of developmental activities should be performed. This should consist of a detailed account of the child's daily activities together with direct observations by a professional person; the latter should include indices or manifestations of social, intellectual, adaptive, verbal, motor (posture, locomotion, manipulation), language, emotional, and self-care development for age. The above should then be related by the evaluating or treating physician to establish developmental norms of the kind found in any widely used standard pediatrics text.

c. *Profound combined mental-neurological-musculoskeletal impairments.* There are children with profound and irreversible brain damage resulting in total incapacitation. Such children may meet criteria in either neurological, musculoskeletal, and/or mental sections; they should be adjudicated under the criteria most completely substantiated by the medical evidence submitted. Frequently, the most appropriate criteria will be found under the mental impairment section.

112.01 Category of Impairments, Mental and Emotional

112.02 *Chronic brain syndrome.* With arrest of developmental progression for at least six months or loss of previously acquired abilities.

112.03 *Psychosis of infancy and childhood.* Documented by psychiatric evaluation and supported, if necessary, by the results of appropriate standardized psychological tests and manifested by marked restriction in the performance of daily age-appropriate activities;

constriction of age-appropriate interests; deficiency of age-appropriate self-care skills; and impaired ability to relate to others; together with persistence of one (or more) of the following:

- A. Significant withdrawal or detachment; or
- B. Impaired sense of reality; or
- C. Bizarre behavior patterns; or
- D. Strong need for maintenance of sameness, with intense anxiety, fear, or anger when change is introduced; or
- E. Panic at threat of separation from parent.

112.04 *Functional nonpsychotic disorders.* Documented by psychiatric evaluation and supported, if necessary, by the results of appropriate standardized psychological tests and manifested by marked restriction in the performance of daily age-appropriate activities; constriction of age-appropriate interests; deficiency of age-appropriate self-care skills; and impaired ability to relate to others; together with persistence of one (or more) of the following:

- A. Psychophysiological disorder (e.g., diarrhea, asthma); or
- B. Anxiety; or
- C. Depression; or
- D. Phobic, obsessive, or compulsive behavior; or
- E. Hypochondriasis; or
- F. Hysteria; or
- G. Asocial or antisocial behavior.

112.05 *Mental retardation.*

A. Achievement of only those developmental milestones generally acquired by children no more than one-half of the child's chronological age; or

- B. IQ of 59 or less; or
- C. IQ of 60-69, inclusive, and a physical or other mental impairment imposing additional and significant restriction of function or developmental progression.

113.00 NEOPLASTIC DISEASES, MALIGNANT

A. *Introduction.* Determination of disability in the growing and developing child with a malignant neoplastic disease as based upon the combined effects of:

1. The pathophysiology, histology, and natural history of the tumor; and
2. The effects of the currently employed aggressive multimodal therapeutic regimens.

Combinations of surgery, radiation, and chemotherapy or prolonged therapeutic schedules impart significant additional morbidity to the child during the period of greatest risk from the tumor itself. This period of highest risk and greatest therapeutically-induced morbidity defines the limits of disability for most of childhood neoplastic disease.

B. *Documentation.* The diagnosis of neoplasm should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen, along with all pertinent laboratory and X-ray reports. The evidence should also include a recent report directed especially at describing whether there is evidence of local or regional recurrence, soft part or skeletal metastases, and significant post therapeutic residuals.

C. *Malignant solid tumors*, as listed under 113.03, include the histiocytosis syndromes except for solitary eosinophilic granuloma. Thus, 113.03 should not be used for evaluating brain tumors (see 111.05) or thyroid tumors, which must be evaluated on the basis of whether they are controlled by prescribed therapy.

D. *Duration of disability* from malignant neoplastic tumors is included in 113.02 and 113.03. Following the time periods designated in these sections, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of a remaining impairment must be evaluated on the basis of the medical evidence.

113.01 Category of Impairments, Neoplastic Diseases—Malignant

113.02 *Lymphoreticular malignant neoplasms.*

A. Hodgkin's disease with progressive disease not controlled by prescribed therapy; or

B. Non-Hodgkin's lymphoma. Consider under a disability:

1. For 2½ years from time of initial diagnosis; or
2. For 2½ years from time of recurrence of active disease.

113.03 *Malignant solid tumors.* Consider under a disability:

- A. For 2 years from the time of initial diagnosis; or
- B. For 2 years from the time of recurrence of active disease.

113.04 *Neuroblastoma.* With one of the following:

- A. Extension across the midline; or
- B. Distant metastases; or
- C. Recurrence; or
- D. Onset at age 1 year or older.

113.05 *Retinoblastoma.* With one of the following:

- A. Bilateral involvement; or
- B. Metastases; or
- C. Extension beyond the orbit; or
- D. Recurrence.

[50 FR 35066, Aug. 28, 1985; 50 FR 38113, Sept. 20, 1985, and 50 FR 50088, Dec. 6, 1985; 51 FR 5989, Feb. 19, 1986; 51 FR 7933, Mar. 7, 1986; 51 FR 16016, Apr. 30, 1986]

**Social Security Ruling (SSR) 83-19
(West's Social Security Reporting Service)
(Rulings Supp. Pamph. 1988)**

**TITLES II AND XVI: FINDING DISABILITY
ON THE BASIS OF MEDICAL CONSIDERATIONS ALONE—
THE LISTING OF IMPAIRMENTS AND MEDICAL
EQUIVALENCY**

PURPOSE: To state the policy and describe the criteria for a finding of disability under titles II and XVI of the Social Security Act based on impairments which meet or equal the Listing of Impairments.

CITATIONS (AUTHORITY): Sections 216(i), 223(d) and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1505, 404.1508, 404.1513, 404.1520(d), 404.1525, 404.1526, 404.1528, 404.1529, 404.1577, 404.1578; and Regulations No. 16, Subpart I, sections 416.905, 416.906, 416.908, 416.913, 416.920(d), 416.923, 416.925, 416.926 and 416.928; Regulations No. 4, Subpart P, Appendix 1, Listing of Impairments.

INTRODUCTION: A finding of disability on medical grounds alone is made when the individual's medical condition is one which meets the specific criteria in the Listing of Impairments (the listing) or is the equivalent of a listed impairment. The criteria in the listing provide the basic frame of reference for the medical evaluation of all disability claims.

The listing contains over 100 examples of medical conditions which ordinarily prevent an individual from engaging in any gainful activity. The listing permits adjudicators to quickly and readily identify those persons who clearly have disabling impairments.

Impairments manifestations are so numerous and varied that it is difficult to include in the listing all the sets of medical findings which describe impairments severe enough to prevent any gainful work. When the individual does not have any impairment specifically described in the listing, a physician designated by the Secretary of the Department of Health and Human Services is called upon to provide an expert medical judgment as to whether the set of symptoms, signs, and laboratory findings of the individual's impairment(s) is equivalent to one of the sets of symptoms, signs, and laboratory findings contained in the listing. If the individual's impairment(s) has the specific medical findings of a listed set of medical findings or findings that are equal in severity and duration to a set of listed findings, the individual is considered to be unable to engage in any gainful activity and, thus, can be found disabled on medical grounds alone.

POLICY STATEMENT: Under the Listing of Impairments, the severity of each listed impairment generally precludes the effective performance of any gainful work activity. If an individual has a medical condition with the specific medical findings described in the listing or one that is the medical equivalent of any listed set of findings (and meets the 12-month duration requirement), a finding of disability will be made in the absence of evidence to the contrary (i.e., performance of substantial gainful activity or failure without a good reason to follow prescribed treatment which is expected to restore the capacity to work).

Under the concept of medical equivalence, a physician designated by the Secretary is required to decide whether the medical findings of an individual's impairment(s), although not specifically described by any listed set of medical criteria in the listing, are at least medically equivalent to one of the listed sets.

Impairments That Meet the Listing

An impairment "meets" a listed condition in the Listing of Impairments only when it manifests the specific findings described in the set of medical criteria for that listed impairment. A finding that an impairment meets the listing will not be justified on the basis of a diagnosis alone.

The "level of severity" of impairments in the listing is not defined in terms of the residual functional capacity (RFC) of the individual. When certain functional limitations are specified for a listed impairment, they relate only to the degree of dysfunction for that particular listing section and only to the specific function identified. For example, Listing 1.10C (inability to use a prosthesis effectively, without obligatory assistive devices), relates *only* to the underlying medical disorder which prohibits the use of a prosthesis and does not *directly* relate to the standing and walking requirements described for the levels of physical exertion in the PPS-102, SSR 83-11, Titles II and XVI: Capability to Do Other Work—The Exertionally Based Medical-Vocational Rules Met.

Impairments That Equal a Listed Impairment

To determine whether an impairment or a combination of impairments is of severity equivalent to a listed impairment, the set of symptoms, signs, and laboratory findings in the medical evidence supporting a claim must be compared with the set of symptoms, signs, and laboratory findings specified for the listed impairment most like the individual's impairment(s). The impairment(s) may be judged to be equivalent to a listed impairment only if the medical findings (defined as a set of symptoms, signs, and laboratory findings) are at least equivalent in severity to

the set of medical findings for the listed impairment. In no instance will symptoms alone justify a finding of equivalence. (See PPS-82, SSR 82-58, Titles II and XVI: Evaluation of Symptoms.)

Equivalency can be found under three circumstances:

1. A *listed* impairment for which one or more of the specified medical findings is missing from the evidence but for which other medical findings of equal or greater clinical significance and relating to the same impairment are present in the medical evidence.
2. An *unlisted* impairment, in which the set of criteria for the most closely analogous listed impairment is used for comparison with the findings of the unlisted impairment.
3. A *combination of impairments* (none of which meet or equal a listed impairment), each manifested by a set of symptoms, signs, and laboratory findings which, combined, are determined to be medically equivalent in medical severity to that listed set to which the combined sets can be most closely related.

Medical equivalence may not be established when the reported medical findings reflect lesser severity than listed criteria require (and there are no related findings of equal or greater medical significance).

As in determining whether the listing is met, it is incorrect to consider whether the listing is equaled on the basis of an assessment of overall functional impairment. The level of severity in any particular listing section is depicted by the *given set* of findings and not by the degree of severity of any single medical finding—no matter to what extent that finding may exceed the listed value.

The mere accumulation of a number of impairments also will not establish medical equivalence. When an individual suffers from a combination of untreated impairments, the medical findings of the combined impairments will be compared to the findings of the listed impairment most similar to the individual's most severe impairment. The functional consequences of the impairments (i.e., RFC), irrespective of their nature or extent, *cannot* justify a determination of equivalence.

Any decision that an individual's impairment(s) is medically the equivalent of a listed impairment must be based on findings demonstrated by medically acceptable clinical and laboratory diagnostic techniques. Decisions of equivalence are the responsibility of a physician designated by the Secretary. In most instances, the designated physician is a physician in the State agency. A medical advisor at a hearing or a member of the Appeals Council's (AC) medical support staff (including medical consultants) may also make the physician's decision in the determination of medical equivalence.

As with any other medical opinion concerning impairment severity for titles II and XVI disability purposes, judgments of the examining physician are not controlling on the issue of equivalence. In every instance, the decision as to equivalence is to be made by a program physician based upon the individual medical findings in the particular case.

Hearings and Appeals

By comparing the clinical signs, symptoms, and laboratory findings from the evidence of record with those in the listing, the administrative law judge (ALJ) can usually readily determine whether the listing is met. By

contrast, a determination that an impairment or combination of impairments is *equal* to a listed impairment requires greater medical expertise. It must be determined whether the medical findings in the record are of at least equivalent *clinical significance* to the findings required in the listing.

At the initial and reconsideration levels, the signature of the State agency staff physician on the SSA-831-U5/SSA-833-U5 serves as the basis for the determination and assures that consideration by a physician designated by the Secretary has been given to the question of medical equivalence. At the hearing level, the ALJ is responsible for deciding the ultimate legal question of whether the listing is met or equaled. As trier of the facts, the ALJ is not *bound* by the medical judgment of a "designated" physician regarding medical equivalency. However, the judgment of a "designated" physician on this issue on the same evidence before the ALJ must be received into the record as expert opinion evidence and given appropriate weight. Furthermore, to assure that proper consideration is given to a medical equivalency opinion from a physician designated by the Secretary, the ALJ must obtain an updated medical judgment from a medical advisor (interrogatories may be used) in the following circumstances:

1. When no additional medical evidence is received, but, in the opinion of the ALJ, the symptoms, signs, and laboratory findings reported in the record suggest that a judgment of equivalency may be reasonable.
2. When additional medical evidence is received which, in the opinion of the ALJ, may change the determination of the SSA-831-U5/SSA-833-U5 that the impairment(s) does not equal the listing.

When an updated medical judgment as to medical equivalency is required at the AC level, the AC must call on the services of its medical support staff (including medical consultants).

The Disability Determination or Decision

PPS-81, SSR 82-56, Titles II and XVI: The Sequential Evaluation Process, discuss the role of the listing in the evaluation process (see also the following section) and also provides some detail about the format and contents of the disability determination or decision. The rationale in the determination or decision must reflect consideration of the pertinent evidence of record and reconcile or resolve significant inconsistencies. When a favorable determination or decision is based on the listing being met or equaled, the *particular* listed impairment which is applicable to the case must be cited, together with the medical findings that meet or equal the listed impairment criteria.

Types of Claims Allowable Only on the Basis of Medical Factors

Title II: Disabled Widow, Widower, or Surviving Divorced Spouse

Regulation section 404.1577 provides that a widow, widower, or surviving divorced spouse must have a medically determinable impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of no less than 12 months. The impairment must be of a level of severity to prevent a person from doing any gainful activity. Regulation section 404.1578 provides that the impairment(s) must have specific medical findings that meet or equal those of any impairment in the Listing of Impairments. Therefore, only

the medical impairment is to be considered and age, education, and work experience are specifically excluded.

Title XVI: Children Under Age 18

Under Regulations sections 416.906 and 416.923, a child under age 18 will be considered disabled if he or she: (a) has a medically determinable impairment which compares in severity to an impairment which would make an adult disabled on the basis of medical evidence alone and (b) is not performing any SGA.

Part B of the Listing of Impairments presents sets of impairment criteria which are particularly applicable to children under age 18 and, consequently, should be considered first. However, when the criteria of part B do not effectively address a child's impairment, the medical criteria in part A may be applied to the evaluation of impairments in persons under age 18 when the disease processes involved have a similar effect upon *both* adults and younger persons. To establish childhood disability, the impairment *must* meet or equal a specific listed set of criteria in either part A or part B of the listing.

EFFECTIVE DATE: The policy explained herein was effective August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

SOCIAL SECURITY ADMINISTRATION
Program Operation Manual System (POMS)
(Disability Insurance (DI))

Medical Evaluation

**Residual Functional Capacity
(RFC)**

References: (CFR 404.1545-1546 and 416.945-.946)

24510.001 GENERAL

Residual functional capacity (RFC) is the remaining capacity to perform work related physical and mental activities despite functional limitations resulting from medically determinable impairments. This concept along with other factors affecting an individual's vocational adjustment (i.e., age, education, and work history) is a factor in those steps in sequential evaluation involving an assessment of ability to do past relevant work or other work.

An RFC assessment must be fully documented to support adjudicative conclusions of what an individual can still do in a work setting, and must be fully responsive to the claimant's statements, including those about symptoms (especially pain) which concern the nature and extent of the impairments.

RFC assessment is the responsibility of the DDS medical consultant and is based primarily on medical findings which must be complete enough to permit and support the necessary judgments concerning the individual's physical, mental, and sensory capacities, and any environmental restrictions. This should include appropriate history, signs, symptoms, clinical and laboratory findings for full documentation.

In addition to formal medical evaluation, such as consultative consultative examinations, test results, descriptions and observations of the claimant's restrictions by both medical and nonmedical sources must be considered in determining an RFC.

When multiple physical and/or mental impairments are involved, the RFC is derived from an assessment of the remaining functional capacity after consideration of all impairments.

The RFC assessment is expressed in terms of a person's capacities and limitations in performing work related activities. An assessment of physical capacities must reflect what an individual can do on a sustained basis.

This includes an evaluation of the capacity to perform basic strength factors such as lifting, carrying, standing, walking, sitting, and pushing or pulling. Other physical factors which must be considered include climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, and fingering. Sensory physical factors such as feeling, seeing and hearing must also be considered as well as the capacity to speak. Environmental restrictions must be described. They include medically imposed restrictions to working around heights, machinery, temperature extremes, dust, fumes, humidity, vibrations, etc.

The RFC considerations for mental impairments include understanding and memory, sustained concentration and persistence, social interaction and adaptation. Each of these broad areas includes specific mental activities which must be addressed in determining a person's capacities and limitations to perform at a sustained level in competitive employment.

22001.020 Does the Individual Have Any Impairment(s) Which Meets or Equals the Listings?

- A. A finding of disability ordinarily will be justified when the individual's impairment is one which is as severe as the impairments contained in the Listing of Impairments. The Listing of Impairments (see Regulations No. 4, Subpart P, Appendix 1) contains over 100 medical conditions which would ordinarily prevent an individual from engaging in any gainful activity. The Listings help to assure that determinations or decisions of disability have a sound medical basis, that claimants receive equal treatment throughout the country, and that the majority of persons who are disabled can be readily identified.
- B. The level of severity described in the Listings is such that an individual who is not engaging in SGA and has an impairment or the equivalent of an impairment described therein is generally considered unable to work by reason of the medical impairment alone. Thus, when such an individual's impairment or combination of impairments meets or equals the level of severity described in the Listings, and also meets the duration requirements (DI 25505.000ff), disability will be found on the basis of the medical facts alone in the absence of evidence to the contrary (e.g., the actual performance of SGA, or failure to follow prescribed treatment without a justifiable reason). The claimant's impairment(s) must meet or equal a listed impairment for a favorable determination or decision to be based on medical consideration alone. (See DI 24505.000ff which further explains the concept of finding disability on medical basis alone.)
- C. For an impairment to be found to be equivalent in severity to a listed impairment, the set of symptoms,

signs and laboratory findings in the medical evidence supporting a claim must be compared with and found to be equivalent in terms of medical severity and duration to the set of symptoms, signs and laboratory findings specified for a listed impairment. When the individual's impairment is not listed, the set for the most closely analogous listed impairment is used.

- D. Where an individual has a combination of impairments, none of which meets or equals a listed impairment, and each impairment is manifested by a set of symptoms and relevant signs and/or abnormal laboratory findings, the collective medical findings of the combined impairments must be matched to the specific set of symptoms, signs, and laboratory findings of the listed impairment to which they can be most closely related. The mere accumulation of a number of impairments will not establish medical equivalency. In no case are symptoms alone a sufficient basis for establishing the presence of a physical or mental impairment.
- E. Any decision as to whether an individual's impairment(s) is medically the equivalent of a listed impairment, must be based on medical evidence demonstrated by medically acceptable clinical and laboratory diagnostic techniques, including consideration of a medical judgment about medical equivalence furnished by one or more physicians designated by the Secretary. The disability determination services physician's documented medical judgment as to equivalency meets this regulatory requirement.

NOTE: Sequential evaluation ends here for disabled widows, widowers, surviving divorced spouses, and children under age 18.

24505.015 Finding Disability on the Basis of Medical Factors Alone

The next step in sequential evaluation is to determine if the individual has an impairment(s) which meets or is equivalent to the listings in the Listing of Impairments. The criteria in the Listing provides the basis frame of reference for the medical evaluation of all disability claims.

A. General

The Listing contains over 100 examples of medical conditions which ordinarily prevent an individual from engaging in any gainful activity. The Listing permits adjudicators to quickly and readily identify those persons who clearly have disabling impairments.

Impairment manifestations are so numerous and varied that it is difficult to include in the Listing all the sets of medical findings which describe impairments severe enough to prevent any gainful work. When the individual does not have any impairment specifically described in the Listing, a DDS medical consultant is called upon to provide an expert medical judgment as to whether the set of symptoms, signs and laboratory findings of the individual's impairment(s) is equivalent to one of the sets of symptoms, signs, and laboratory findings contained in the Listing. If the individual's impairment(s) has the specific medical findings of a listed set of medical findings or findings that are equal in severity and duration to a set of listed findings, the individual is not considered to be able to engage in any gainful activity and thus, can be found disabled on medical grounds alone.

Under the Listing of Impairments, the severity of each listed impairment generally precludes the effective performances of any gainful work activity. If an individual has a medical condition with the specific medical

findings described in the Listing or one that is the medical equivalent of any listed set of findings (and meets the 12-month's duration requirement), a finding of disability will be made in the absence of evidence to the contrary (e.g., performance of substantial gainful activity or failure without a good reason to follow prescribed treatment which is expected to restore the capacity to work).

Under the concept of medical equivalence, a DDS medical consultant is required to decide whether the medical findings of an individual's impairment(s), although not specifically described by any listed set of medical criteria in the Listing, is at least medically equivalent to one of the listed sets.

B. Impairments That Meet the Listing

An impairment "meets" a listed condition in the Listing of Impairments only when it manifests the specific findings described in the set of medical criteria for that listed impairment. A finding that an impairment meets the Listing will not be justified on the basis of a diagnosis alone.

The "level of severity" of impairments in the listing is not defined in terms of the residual functional capacity (RFC) of the individual. When certain functional limitations are specified for a listed impairment, they relate only to the degree of dysfunction for the particular listing section and only to the specific function identified.

C. Impairments That Equal a Listed Impairment

To determine whether an impairment or a combination of impairments is of severity equivalent to a listed impairment, the set of symptoms, signs, and laboratory findings in the medical evidence supporting a claim must be compared with the set of symptoms, and laboratory findings

specified for the listed impairment most like the individual's impairment(s). The impairment(s) may be judged to be equivalent to a listed impairment only if the medical findings (defined as a set of symptoms, signs, and laboratory findings) are at least equivalent in severity to the set of medical findings for the listed impairment. In no instance will symptoms alone justify a finding of equivalence. (See DI 24515.060, Evaluation of Symptoms.)

Equivalency can be found under three circumstances.

1. LISTED IMPAIRMENTS

A listed impairment for which one or more of the specified medical findings is missing from the evidence but for which other medical findings of equal or greater clinical significance and relating to the same impairment are present in the medical evidence.

2. UNLISTED IMPAIRMENTS

An unlisted impairment, in which the set of criteria for the most closely analogous listed impairment is used for comparison with the findings of the unlisted impairment.

3. MULTIPLE IMPAIRMENTS

A combination of impairments (none of which meet or equal a listed impairment), each manifested by a set of symptoms, signs and laboratory findings which, combined, are determined to be medically equivalent in medical severity to that listed set to which the combined sets can be most closely related.

Medical equivalence may not be established when the reported medical findings reflect lesser severity than listed criteria require (and there are no related findings of equal or greater medical significance).

As in determining whether the listing is met, it is incorrect to consider whether the listing is equaled on the basis of an assessment of overall functional impairment. The level of severity in any particular listing section is depicted by the given set of findings and not by the degree of severity of any single medical finding—no matter to what extent that finding may exceed the listed value.

The mere accumulation of a number of impairments also will not establish medical equivalence. When an individual suffers from a combination of unrelated impairments, the medical findings of the combined impairments will be compared to the findings of the listed impairment most similar to the individual's most severe impairment. The functional consequences of the impairments (i.e., RFC), irrespective of their future or extent, cannot justify a determination of equivalence.

Any decision that an individual's impairment(s) is medically the equivalent of a listed impairment must be based on findings demonstrated by medically acceptable clinical and laboratory diagnostic techniques. Decisions of equivalence are the responsibility of a physician designated by the Secretary. In most instances, the designated physician is a physician in the State agency. A medical advisor at a hearing or a member of the Appeals Council's (AC) medical support staff (including medical consultants) may also make the physician's decision in the determination of medical equivalence.

As with any other medical opinion concerning impairment severity for title II and the title XVI disability purposes, judgments of the examining physician, which they may be of considerable weight, are not controlling on the issue of equivalence. In every instance, the decision as to equivalence is to be made by a program physician based upon the individual medical findings in the particular case.

D. The Disability Determination or Decision

The rationale in the determination or decision must reflect consideration of the pertinent evidence of record and reconcile or resolve significant inconsistencies. When a favorable determination or decision is based on the listing being met or equaled, the particular listed impairment which is applicable to the case must be cited, together with the medical findings that meet or equal the listed impairment criteria.

E. Types of Claims Allowable Only on the Basis of Medical Factors—Title II-DWB and Title XVI-DC

1. Title II: Disabled Widow, Widower, or Surviving Divorced Spouse

CFR 404.1577 provides that a widow, widower, or surviving divorced spouse must have a medically determinable impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of no less than 12 months. The impairment must be of a level of severity to prevent a person from doing any gainful activity. Regulation section 404.1578 provides that the impairment(s) must have specific medical findings that meet or equal those of any impairment in the Listing of Impairments. Therefore, only the medical impairment is to be considered and age, education, and work experience are specifically excluded.

2. TITLE XVI: CHILDREN UNDER AGE 18

Under CFR 416.906 and 416.923, child [sic] under age 18 will be considered disabled if he or she: (a) has a medically determinable impairment which compares in severity to an impairment which would make an adult disabled on the basis of medical evidence alone and (b) is not performing any SGA.

Part B of the Listing of Impairments presents acts of impairment criteria which are particularly applicable to

children under age 18 and, consequently, should be considered first. However, when the criteria of part B do not effectively address a child's impairment, the medical criteria in part A may be applied to the evaluation of impairments in persons under age 18 when the disease processes involved have a similar effect upon both adults and younger persons. To establish childhood disability, the impairment must meet or equal a specific listed set of criteria in either part A or part B of the listing.

24501.025 Evaluation of Symptoms

A. General

Symptoms such as pain, shortness of breath, weakness, or nervousness are the individual's own perceptions of the effects of a physical or mental impairment(s). Because of their subjective characteristics and the absence of any reliable technique for measurement, symptoms (especially pain) are difficult to prove, disprove, or quantify.

Symptoms will not have a significant effect on a disability determination or decision unless medical signs or findings show that a medical condition is present that could reasonably be expected to produce the symptoms which are alleged or reported. However, once such a medical condition (e.g., disc disease) is objectively established, the symptoms are still not controlling for purposes of evaluating disability. Clinical and laboratory data and a well-documented medical history must establish findings which may reasonably account for the symptom in a particular impairment. Objective clinical findings can be used to draw reasonable conclusions about the validity of the intensity and persistence of the symptoms and about its effect on the individual's work capacity. For example, in cases of back pain associated with disc disease, typical

associated findings are muscle spasm, sensory loss, motor loss, and atrophy. There must be an objective basis to support the overall evaluation of impairment severity. It is not sufficient to merely establish a diagnosis or a source for the symptom.

When symptoms are alleged as a significant aspect of the impairment but the criteria for a listed impairment are not met or equaled and a severe impairment exists, the symptoms must be considered in evaluating disability and must be addressed in the disability determination or decision. The following sequential evaluation process facilitates that consideration.

See DI 24515.060 for evaluation of pain.

B. Need to Establish a Medically Determinable Severe Impairment

To be found disabled under the law, an individual must have a medically determinable severe impairment, i.e., an impairment which has demonstrable anatomical, physiological or psychological abnormalities. Such abnormalities are medically determinable if they manifest themselves through medical evidence consisting of symptoms, signs, and laboratory findings. Symptoms, alone, however, do not constitute a basis for finding a medically determinable impairment.

If no medically determinable *physical* impairment is found, yet the person alleges work-related limitations due to a symptom normally attributable to a physical impairment, the possibility of a medically determinable severe *medical* impairment must be considered. When a medically determinable severe impairment cannot be established on either a physical or a mental basis, the claim must be denied, regardless of the intensity of the symptom, related limitations alleged, or any judgments by examining medical sources about the effects of the symptom.

C. Decide Whether the Listing Is Met or Equaled

When a medically determinable severe impairment or combination of impairments is documented, the next step is to determine whether the Listing of Impairments is met or equaled. The Listing of Impairments includes requisite symptoms in certain circumstances. In determining whether a listed set of criteria which includes a symptom as one criterion is met, ordinarily it is essential only that the symptom(s) be present, *in combination* with the required clinical signs and laboratory findings. Unless specifically stated in the Listing, quantification or other evaluation of the degree of functionally limiting effects of that symptom is not required to determine whether the criteria is a listed impairment are met.

If the listed criteria are not met, consider whether the impairment equals a set of symptoms and findings in the Listing. However, if the requisite clinical signs and laboratory findings, or other findings of equal or greater significance are not present, the symptom cannot be persuasive that the Listing is met or equaled. *No alleged or reported intensity of the symptoms can be substituted to elevate impairment severity to equivalency.* For example, if pain is present and is a requisite for a listed impairment, but one (or more) of the requisite clinical or laboratory findings for meeting the Listing is missing or is of a lesser value, complaints of "severe," "extreme," or "constant" pain will not compensate for the missing medical findings and permit an "equals" determination.

D. Determine the Impact of Symptoms on Residual Functional Capacity

When the listed impairment criteria are not met or equaled but one or a combination of impairments is severe, an RFC assessment must be made. In assessing

symptoms such as pain as a factor of RFC, the functionally limiting effects of the symptom can play a significant role. See DI 24510.030 for impact of symptoms on RFC.

24510.030 The Impact of Symptoms on Residual Functional Capacity

When the listed impairment criteria are not met or equaled but one or more impairments are severe, an RFC assessment must be made. In assessing symptoms such as pain, as a factor of RFC, the functionally limiting effects of the symptom can play a significant role. The effects of symptoms must be considered in terms of any additional physical or mental restrictions they may impose beyond those clearly demonstrated by the objective physical manifestations of disorders. Symptoms can sometimes suggest a greater severity of impairment than is demonstrated by objective medical findings alone. However, since symptoms such as pain, are subjective and cannot be quantified by any reliable method, any additional symptom-related functional limitations must largely be inferred from the history and the objective physical findings (e.g., reduced joint motion, muscle wasting, muscle spasm, sensory and motor disruption) and from medical knowledge as to what symptom-related effects on functional capacity can be reasonably expected. In assessing allegations of disabling symptoms, consideration should be given to data such as the alleged frequency and duration of the symptom (with pain, location and radiation); precipitating or aggravating factors; effect on daily activities; and dosage, effectiveness, and side-effects of medication; as well as any recorded observations about symptoms by persons such as examining physicians and Social Security Administration employees (district office representatives, administrative law judges, etc.). Reasonable conclusions can be drawn from such informa-

tion concerning both the presence and persistence of the symptom and its effects and any resultant additional diminution of RFC.

There may be an emotional component to all symptoms, but the fact that an individual may seem to be exaggerating the limitations arising from a symptom does not necessarily mean that the symptom or the alleged functional limitation is in any way the result of an emotional disorder. However, when alleged symptom-related limitations are clearly out of proportion to physical findings (e.g., no clinical findings of severe neuromuscular disorder, yet the individual alleges inability to stand, bend, or walk due to constant pain), the *possibility* of a severe mental impairment should be investigated. Consequently, if there are unconfirmed but alleged significant functional limitations and medical evidence received from treating and examining medical sources does not resolve whether a severe mental impairment is present, we will consider obtaining a psychiatric evaluation. (See DI 24510.075 for evaluation of symptoms in mental disorder cases.)

When a severe psychiatric impairment is demonstrated, conclusions about the significance of pain, or of any other symptom of emotional origin, will be based on the determination of the severity of the mental impairment and the resultant limitation of activities, interests, personal habits, and ability to relate to others.

Thorough and comprehensive RFC assessments become most critical in denial determinations and decisions, when the persistence or the extent of alleged or reported symptom-related limitations is (1) not consistent with the severity of the physical impairment which has been established and (2) not explainable on a psychiatric basis. In those situations, it is essential to identify and resolve all conflicting medical source conclusions and claimant

allegations about functional capacity. The RFC assessment must convey the reason(s) why the alleged or reported symptom-related functional limitation is not supported by the evidence. Statements by the treating or examining sources or by the individual which are consistent with the ultimate conclusion as to functional capacity should also be included in the RFC discussion.

See DI 24515.060 for evaluation of pain.

SOCIAL SECURITY ADMINISTRATION
Program Operations Manual System (POMS) (1984)
(Disability Insurance (DI))

Case Development and Evaluation

* * * * *

**00401.336 Inability To Engage In Any Gainful Activity: Title II
 Widow, Widower or Surviving Divorced Spouse/Title
 XVI Child Under Age 18**

In the Listing of Impairments, the regulations describe impairments of a level of severity deemed to preclude an individual from engaging in *any* gainful activity. An applicant for title II disabled widow's, widower's, or surviving divorced spouse's benefits or title XVI child's benefits *must* have an impairment(s) that meets or equals an impairment in the Listing.

As in the case of a title II worker or CDB applicant or a title XVI claimant age 18 or older, a title II widow(er), or title XVI child whose work demonstrates ability to engage in SGA is not under a disability. The level of severity of an impairment which a title II widow(er) or a title XVI child must meet or equal to be determined to be under a disability is that which is considered under the regulations to be sufficient to preclude engaging in *any gainful* activity (i.e., must meet or equal the Listings), as distinguished from SGA. The concept of "gainful activity," however, is used only in setting the requisite level of severity of the impairment in the Listing of Impairments and not otherwise.

In the Supreme Court of the United States

No. 88-1377

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN
SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

ORDER ALLOWING CERTIORARI. Filed May 15, 1989.

The petition herein for a writ of certiorari to the United
States Court of Appeals for the Third Circuit is granted.

MAY 15, 1989

(5)
No. 88-1377

Supreme Court, U.S.

FILED

JUL 11 1989

JOSEPH P. DANIEL, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1989

LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

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6488

QUESTION PRESENTED

Whether regulations issued by the Secretary of Health and Human Services to govern the adjudication of claims for child's disability benefits under the Supplemental Security Income program established by Title XVI of the Social Security Act are consistent with the statutory provision that an individual under age 18 shall be considered to be disabled if he suffers from "any medically determinable physical or mental impairment of comparable severity" to one that would lead to a determination that an adult is disabled (42 U.S.C. 1382c(a)(3)(A)).

PARTIES TO THE PROCEEDING

The petitioner is the Secretary of Health and Human Services. The respondents are plaintiff Brian Zebley and intervenors Evelyn Raushi and Joseph Love, Jr., who represent a class, certified by the district court, of "[a]ll persons who are now, or who in the future will be, entitled to an administrative determination (whether initially, on reconsideration or on reopening) as to whether supplemental security income benefits are payable on account of a child who is disabled" (Pet. App. 6a).

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In the Supreme Court of the United States

OCTOBER TERM, 1989

No. 88-1377

LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-20a) is reported at 855 F.2d 67. The memorandum and order of the district court (Pet. App. 21a-24a) are reported at 642 F. Supp. 220.

JURISDICTION

The judgment of the court of appeals was entered on August 10, 1988, and a petition for rehearing was denied on October 18, 1988 (Pet. App. 25a). On January 9, 1989, Justice Brennan extended the time within which to file a petition for a writ of certiorari to and including February 15, 1989. The petition was filed on that date and was granted on May 15, 1989 (J.A. 260). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 1614(a)(3)(A) and (B) of the Social Security Act, 42 U.S.C. 1382c(a)(3)(A) and (B); Section 501(b) of the Unemployment Compensation Amendments of 1976, Pub. L. No. 94-566, 90 Stat. 2685; and 20 C.F.R. 416.924-416.926, are reproduced at App., *infra*, 1a-5a. Parts A and B of the Listing of Impairments in 20 C.F.R. Pt. 404, Subpt. P, Appendix 1, are reproduced at J.A. 115-235.

STATEMENT

A. The Statutory and Regulatory Scheme

1. The Supplemental Security Income (SSI) program established by Title XVI of the Social Security Act, 42 U.S.C. 1381 *et seq.* (1982 & Supp. IV 1986), provides for the payment of benefits to financially needy individuals who are aged, blind, or disabled. Unlike Title II of the Act, 42 U.S.C. 401 *et seq.* (1982 & Supp. IV 1986), which is an insurance program, Title XVI furnishes benefits without regard to insured status and is in the nature of a welfare program. *Bowen v. Galbreath*, 108 S. Ct. 892, 893 (1988).

The SSI program was enacted in 1972 and went into effect on January 1, 1974.¹ It replaced three of the four categorical assistance programs that previously had been funded under the Social Security Act, leaving in place only the Aid to Families with Dependent Children program under Title IV of the Act, 42 U.S.C. 601 *et seq.* (1982 & Supp. IV 1986). *Schweiker v. Gray Panthers*, 453 U.S. 34, 37-39 & n.1 (1981); *Schweiker v. Hogan*, 457 U.S. 569, 581-582 (1982). The SSI program was principally intended "[t]o assist those who cannot work because of age, blindness, or disability," by 'set[ting] a

¹ Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 301-306, 86 Stat. 1465-1485; *Schweiker v. Wilson*, 450 U.S. 221, 223 (1981).

Federal guaranteed minimum income level for aged, blind, and disabled persons.'" *Schweiker v. Wilson*, 450 U.S. 221, 223 (1981), quoting S. Rep. No. 1230, 92d Cong., 2d Sess. 4, 12 (1972).² However, it also provides for the payment of benefits to children under age 18 who are considered to be disabled. 42 U.S.C. 1382c(a)(3)(A). This case concerns the standards utilized by the Secretary of Health and Human Services to determine whether a child is disabled for purposes of the SSI program.

2. The Social Security Act provides that "[a]n individual shall be considered to be disabled" for purposes of the SSI program if he is unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to * * * last for a continuous period of not less than twelve months" (42 U.S.C. 1382c(a)(3)(A)).³ This definition is identical to and was patterned after the definition in 42 U.S.C. 423(d)(1)(A), which is used in evaluating adult claimants under the Title II insurance program. See *Bowen v. Yuckert*, 482 U.S. 137, 140 (1987); S. Rep. No. 1230, *supra*, at 384. Because this vocationally oriented standard could not sensibly be applied to children (see pages 29-30, 36-37, *infra*), Congress further provided in Section 1382c(a)(3)(A) that

² To be eligible for SSI benefits, an individual's income and resources must be below the levels specified in 42 U.S.C. 1382(a) (1982 & Supp. IV 1986). *Schweiker v. Wilson*, 450 U.S. at 223 n.2. See also 42 U.S.C. 1382a (definition of and exclusions from income), 1382b (1982 & Supp. IV 1986) (exclusions from resources).

³ Section 4 of the Social Security Disability Benefits Reform Act of 1984 (1984 Act), Pub. L. No. 98-460, 98 Stat. 1800, which became effective on December 1, 1984, requires that the combined effect of multiple impairments be considered throughout the disability determination process. See 42 U.S.C. 1382c(a)(3)(F) (Supp. IV 1986); *Bowen v. Yuckert*, 482 U.S. 137, 150-151 (1987). For convenience, however, we shall use the singular term "impairment" in this brief.

an individual under the age of 18 shall be considered to be disabled "if he suffers from any medically determinable physical or mental impairment of *comparable severity*" (emphasis added).

The basic definition of disability in paragraph (A) of 42 U.S.C. 1382c(a)(3) is supplemented by paragraph (B), which provides that "an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy." This provision, which also is drawn directly from the Title II program (see 42 U.S.C. 423(d)(2)(A)), was originally enacted in 1967 in order to further describe the circumstances under which benefits may be awarded to adult claimants under Title II. *Yuckert*, 482 U.S. at 147-148. From the outset of the SSI program, the Secretary has interpreted the corresponding language in Section 1382c(a)(3)(B) that provides for consideration of non-medical factors—the claimant's "age, education and work experience"—to be inapplicable to children, because the statutory text contemplates that those factors will be taken into account only where it is appropriate to assess a claimant's ability to work. See pages 36-39, *infra*.

3. In 1978, the Secretary formally established a five-step sequential evaluation process for determining whether an adult is disabled for purposes of the SSI program. 20 C.F.R. 416.920; see *Heckler v. Campbell*, 461 U.S. 458, 460 (1983).⁴ Although that process is not fully utilized in reviewing claims for child's disability benefits, an understanding of its operation will serve to illuminate the issues in this case.

⁴ The sequential evaluation process under Title XVI is essentially the same as that under Title II. See 20 C.F.R. 404.1520; *Yuckert*, 482 U.S. at 140-142.

At step one of the sequential evaluation process, if an adult claimant is found to be engaged in substantial gainful activity, he is denied benefits. 20 C.F.R. 416.920(b). At step two, the claimant likewise is denied benefits if he fails to demonstrate that he has a "severe" impairment—i.e., one that significantly limits his physical or mental ability to do basic work activities. 20 C.F.R. 416.920(c).⁵

If the claimant does have a "severe" impairment, the decision-maker then must determine at step three whether that impairment is included in the Listing of Impairments in Appendix 1 to the regulations (Pt. 404, Subpt. P) or is equal in severity to a listed impairment. 20 C.F.R. 416.920(d); see also 20 C.F.R. 416.925, 416.926. If the impairment is listed, or is medically equivalent to a listed impairment, then it is "acknowledged by the Secretary to be of sufficient severity to preclude gainful employment." *Bowen v. City of New York*, 476 U.S. 467, 470-471 (1986); see also *Yuckert*, 482 U.S. at 141.⁶ Part A of the Listing is applicable to adults aged 18 and over. 20 C.F.R. 416.925(b)(1). Part A is subdivided into categories of impairments affecting each principal body system, and it specifies in detail the medical "criteria" for each impairment—i.e., the medical signs, findings, and symptoms and the requisite level of severity—that, if met, are considered sufficient in themselves to preclude gainful employment and therefore to result in a finding of disability on medical grounds alone. 20

⁵ The step two severity regulation was sustained by this Court in *Yuckert*.

⁶ We have reproduced the Listing at J.A. 115-235. The Listing appears as Appendix 1 to 20 C.F.R. Part 404, Subpart P, which governs disability determinations under the Title II program; it is not duplicated in Part 416 of 20 C.F.R., which governs Title XVI. The medical criteria in the adult portion of the Listing in Part A of Appendix 1 are applicable to both Title II and Title XVI. The additional medical criteria in the children's section of the Listing in Part B are applicable only to individuals under age 18.

C.F.R. 416.925(e) and (c). In addition, if the claimant's impairment is not included in the Listing, but the signs, findings and symptoms associated with it are medically equivalent to a listed impairment, he will be considered to be disabled on medical grounds alone. 20 C.F.R. 416.926. Accordingly, the regulations inform the claimant that if his impairment either meets or equals a listed impairment, "we will find you disabled without considering your age, education, and work experience." 20 C.F.R. 416.920(d).

If the adult claimant's impairment does not meet or equal a listed impairment, vocational considerations are then taken into account (together with medical factors) at steps four and five. See 20 C.F.R. 416.960. At step four, the decision-maker must determine whether the claimant is able to do his own relevant past work, despite his impairment; if so, he is considered not to be disabled. 20 C.F.R. 416.920(e), 416.961. But if the claimant cannot do his past work, the decision-maker then must determine at step five whether, considering the claimant's age, education and work experience, he can do other work that exists in the national economy; if so, he is considered not to be disabled. 20 C.F.R. 416.920(f), 416.962-416.969; see *Yuckert*, 482 U.S. at 141-142; *City of New York*, 476 U.S. at 471. Thus, the non-medical (or "vocational") factors of age, education and work experience—those specifically mentioned in 42 U.S.C. 1382c(a)(3)(B)—are taken into account at step five only if the decision-maker cannot determine at steps two and three that an adult claimant either is or is not disabled based on medical evidence alone and cannot determine at step four that the claimant is unable to perform his own past relevant work. 20 C.F.R. 416.920, 416.960.

In order to determine at steps four and five whether the claimant is able to do his own past work or other work in the national economy, the regulations provide for the decision-maker to assess the claimant's "residual functional capacity" (RFC). The RFC "is what [the

claimant] can still do despite [his] impairment" (20 C.F.R. 416.945); it "measures the claimant's capacity to engage in basic work activities." *City of New York*, 476 U.S. at 471. Thus, the RFC assessment is an evaluative device used to assist the decision-maker in making the determination that is expressly provided for by 42 U.S.C. 1382c(a)(3)(B) in the case of adults: whether a claimant whose impairment is not sufficiently severe based on medical considerations alone to be deemed disabling, nevertheless is disabled because he is unable to perform his own past work (when the demands of that job are considered together with his RFC) and also is unable to perform other work that exists in the national economy (when his age, education and work experience are considered together with his RFC). 20 C.F.R. 416.945(a).⁷

4. As noted above, although the basic definition of disability in 42 U.S.C. 1382c(a)(3)(A) provides that an adult claimant will be found disabled if he is unable to engage in any substantial gainful activity by reason of his impairment, a parenthetical clause at the end of paragraph (A) separately provides that an individual under age 18 will be considered disabled if he suffers from an impairment of "comparable severity." To give content to the standard of "comparable severity," the Secretary has promulgated regulations that provide for the evaluation of children seeking SSI disability benefits in a manner that is identical to that for adults in some respects but different (although parallel) in others.

Like adult claimants, children seeking disability benefits must not be engaged in substantial gainful activity and must suffer from an impairment that is likely to last at least twelve consecutive months. 20 C.F.R. 416.924(a)

⁷ Section 416.945(a) of the regulations informs the claimant that "[t]his assessment of your remaining capacity for work is not a decision on whether you are disabled, but is used as the basis for determining the particular types of work you may be able to do despite your impairment."

and (b) (1). In addition, a child will be found disabled if his impairment meets or equals one of the impairments contained in the Part A Listing utilized for adults—if, for the particular impairment in the Part A Listing, “the disease processes have a similar effect on adults and younger persons.” 20 C.F.R. 416.925(b) (1); see 20 C.F.R. 416.924(b) (2) and (3).

Vocational considerations, however, have little relevance in the evaluation of individuals under age 18, because children rarely have any significant history of past employment and generally are not expected to engage in substantial gainful activity. Consequently, under the Secretary’s regulations, a child whose impairment does not meet or equal an impairment in the adult Part A Listing is not then evaluated on the basis of his capacity to perform prior work or other work in the national economy (in light of his RFC, age, education, and work experience). Instead, an individual under age 18 is evaluated under a special Listing of Impairments in Part B of Appendix 1 containing additional medical criteria that are deemed sufficiently severe in children to be disabling. See 20 C.F.R. 416.924(b) (2) and (3), 416.925(b) (2).⁸ The Secretary explained when he formally published the Part B Listing in 1977 that the physicians and other experts who assisted in developing it “placed primary emphasis on the effects of physical and mental impairments in children, the impact of the impairment on the child’s activities, and the restrictions on growth, learning, and development imposed on the child by the impairments.” 42 Fed. Reg. 14,705 (1977). “Those impairments which were determined to impact on the child’s

⁸ The regulations explain that this additional Listing in Part B is included because “[c]ertain criteria in Part A do not give appropriate consideration to the particular effects of the disease processes in children; i.e., when the disease process is generally found only in children or when the disease process differs in its effect on childhood than on adults.” 20 C.F.R. 416.925(b) (2).

development to the same extent that the adult criteria have on an adult’s ability to engage in substantial gainful activity were deemed to be of ‘comparable severity’ to the adult listing.” *Ibid.*

B. The proceedings in this case

1. This action was filed by respondent Brian Zebley in the United States District Court for the Eastern District of Pennsylvania on July 12, 1983 (Pet. App. 5a; J.A. 1, 16-25). Zebley had been granted child’s disability benefits in September 1980, when he was two years old, on the basis of congenital brain damage with spastic right hemiparesis (a weakness affecting the muscles) and mental retardation (J.A. 20-21, 28). After a scheduled periodic review of his eligibility, Zebley was found no longer to be disabled as of June 1982, on the ground that the then-current medical evidence demonstrated that his impairments no longer met or equaled the criteria in the Listings of Impairments. The ALJ agreed that Zebley was no longer disabled (J.A. 40-47), and the Appeals Council denied review (J.A. 38-39). In his individual action for judicial review under 42 U.S.C. 405(g) and 1383(c) (3), Zebley contended that the decision terminating his benefits was not supported by substantial evidence (Pet. App. 5a-6a; see J.A. 23).

Zebley also sought to represent a class of applicants for and recipients of child’s disability benefits. On behalf of the class, he alleged that the Secretary’s policies and regulations for evaluating child’s disability claims violate 42 U.S.C. 1382c(a) (3) (A), because they do not provide for “individualized consideration of pertinent facts such as capacity to undertake basic activities, learning, growth, development, academic attainment, school performance and capacities and functional limitations imposed by physical or mental impairments” (J.A. 22; see Pet. App. 6a). Zebley contended that such an assessment is re-

quired for children because the Secretary considers both medical and vocational factors in evaluating adults and because 42 U.S.C. 1382c(a)(3)(A) provides that a child shall be considered to be disabled if he suffers from an impairment of "comparable severity" (J.A. 21-23).⁹

On January 10, 1984, the district court certified a class consisting of "[a]ll persons who are now, or who in the future will be, entitled to an administrative determination (whether initially, on reconsideration, or on reopening) as to whether [SSI] benefits are payable on account of a child who is disabled, or as to whether such benefits have been improperly denied, or improperly terminated, or should be resumed" (Pet. App. 6a; J.A. 26-27). Thereafter, on October 12, 1984, the court granted Zebley's motion for partial summary judgment on his individual claim. It held that the Secretary's decision terminating Zebley's benefits was not supported by substantial evidence that his medical condition had improved, as was then required in disability cessation cases by the Third Circuit's decision in *Kuzmin v. Schweiker*, 714 F.2d 1233, 1237 (1983). Pet. App. 6a; see J.A. 28-35.¹⁰

With respect to the class claim, however, the district court, in a decision dated July 16, 1986, granted the Secretary's motion for summary judgment (Pet. App.

⁹ In the fall of 1983, the district court granted motions to intervene filed by Joseph Love, Jr., whose claim for SSI child's disability benefits had been denied (J.A. 48-58), and Evelyn Raushi, whose SSI child's disability benefits had been terminated (J.A. 59-66). Pet. App. 6a.

¹⁰ Similarly, on March 13, 1985, the court granted the Secretary's uncontested motion to remand intervenor Raushi's claim to the Secretary for redetermination under the new statutory "medical improvement" standard in Section 2 of the 1984 Act, 98 Stat. 1794, 42 U.S.C. 423(f) (Supp. IV 1986) (J.A. 36). Compare *Heckler v. Kuehner*, 469 U.S. 977 (1984); *Heckler v. Lopez*, 469 U.S. 1082 (1984).

21a-24a). It rejected respondents' contention that the regulations are invalid on their face because "a child claimant should have the same opportunity to prove inability to function adequately in a child's environment as that which is provided the adult claimant under the 'residual functional capacity' rubric" (*id.* at 23a). Relying on decisions of the First and Eleventh Circuits rejecting "[s]trikingly similar challenges" (*ibid.*, citing *Hinckley v. Secretary of HHS*, 742 F.2d 19 (1st Cir. 1984), and *Powell v. Schweiker*, 688 F.2d 1357 (11th Cir. 1982)), the court concluded that "the Secretary's listing[] of impairments * * * is not facially invalid or incomplete, seems to provide the necessary flexibility, and * * * permits the award of benefits in conformity with the intent of Congress" (Pet. App. 23a, 24a). "If these criteria are being misapplied or misinterpreted," the court noted, "the remedy lies in the appeal process in individual cases, not in a class-action decree" (*id.* at 24a).¹¹

2. The court of appeals reversed and remanded the case to the district court with directions to enter summary judgment in favor of the plaintiff class (Pet. App.

¹¹ After disposing of the class claim, the court, on April 23, 1987, granted the stipulated motion by the Secretary and the remaining named plaintiff, intervenor Love, to remand his claim to the Secretary to be reevaluated under the revised criteria in the listing of mental impairments that were issued by the Secretary pursuant to Section 5(a) of the 1984 Act, 98 Stat. 1801 (J.A. 37). See 50 Fed. Reg. 55,069 (1985); *City of New York*, 476 U.S. at 486 n.14. In a decision dated July 29, 1988, the Appeals Council held, on the basis of the ALJ's extensive review of the evidence, that Love did not have an impairment that met or equaled a listed impairment prior to November 15, 1985, but that he did have a mental impairment (a personality disorder) that equaled the criteria in Section 12.08 of both the adult and child's Listings after that date. On December 15, 1988, Love filed a motion in the instant case to remand his claim back to the Secretary for reevaluation of his eligibility for the period prior to November 13, 1985, in light of the Third Circuit's holding in this case that the Secretary may not rely solely on the Listings in child's disability cases.

1a-20a). The court acknowledged that the SSI statute grants the Secretary "full power and authority to make rules and regulations and to establish procedures" to implement the SSI program, as long as they are "not inconsistent" with the statute (*id.* at 9a, quoting 42 U.S.C. 405(a); see 42 U.S.C. 1383(d)(1) (1982 & Supp. IV 1986)); and it further acknowledged that "Congress did not describe explicitly a *method* for determining whether a claimant is disabled" (Pet. App. 9a (emphasis in original)). Nevertheless, the court invalidated the child's disability regulations to the extent they provide that a claimant is disabled only if he has an impairment that meets or equals a listed impairment and do not provide for an individualized assessment of a claimant's functional limitations in the same manner that the Secretary makes an assessment of an adult claimant's RFC (*id.* at 9a-17a, 20a).

The court of appeals rested its conclusion principally on the language in 42 U.S.C. 1382c(a)(3)(A) stating that a claimant shall be considered disabled if he suffers from "any" impairment that is of comparable severity. See Pet. App. 7a, 11a, 12a, 13a, 17a. In the court's view, because the regulations provide for "individualized assessment of the *actual* degree of functional impairment of adults whose medical findings do not entitle them to a *presumption* of disability by meeting or equaling the listings," children "[must] be given the opportunity to show that they suffer from 'any' impairment of 'comparable severity' to one which would actually, even if not presumptively, disable an adult" (Pet. App. 11a-12a (emphasis in original)).

The court of appeals acknowledged that it was "in the minority among courts which have considered the legality of these regulations" (Pet. App. 16a), but it declined to follow the decisions of other courts sustaining the Secretary's approach. The court specifically rejected the Eleventh Circuit's conclusion in *Powell*, 688 F.2d at 1360, that the Listing of children's impairments in Part B satisfies the statutory "comparable severity" requirement

because the severity of some impairments is evaluated in terms of a child's ability to perform age-appropriate activities, which is sufficiently "comparable to [consideration of] vocational factors for adults" (Pet. App. 13a). In its view, this parallel for some impairments did not satisfy the statutory language that a child's disability may be based on "any" impairment of comparable severity. The court also rejected the First Circuit's conclusion in *Hinckley*, 742 F.2d at 23, that the Secretary's regulations "allow[] for an assessment of a child's mental or physical limitations on an individual basis by providing that a child may be found disabled if his impairment 'is determined by [the Secretary] to be medically equal to an impairment listed in [the appendix].'" The court recognized that medical equivalence to a listed impairment must be based on medical findings, that "it is functional impairment which is meant to be evidenced by the medical findings," and that "[i]t is *only* impaired ability to function which results in disability" (Pet. App. 13a (emphasis in original)). But, relying on a statement in Social Security Ruling (SSR) 83-19 (see J.A. 236-243) that RFC is not considered in determining medical equivalence (J.A. 240), the court held that "something more is necessary in order to determine whether the degree of a claimant's impairment satisfies the statutory standard for disability" (Pet. App. 13a).

Although the court of appeals invalidated the child's disability regulations to the extent they require a claimant's impairment to meet or equal the Listing, it rejected respondents' contention that those regulations are inconsistent with the requirement in Section 4 of the Social Security Disability Benefits Reform Act of 1984 that the Secretary consider the combined effect of several impairments. See 42 U.S.C. 1382c(a)(3)(F) (Supp. IV 1986); *Yuckert*, 482 U.S. at 150-152. The court explained that the regulations incorporate the statutory mandate "by providing expressly that multiple impairments will be considered in assessing medical equivalence,

20 C.F.R. § 416.926, and by providing generally that the combined effect of all of a claimant's impairments will be considered throughout the disability determination process. 20 C.F.R. § 416.923." Pet. App. 18a.¹²

INTRODUCTION AND SUMMARY OF ARGUMENT

The court of appeals in this nationwide class action invalidated the regulations that have been utilized by the Secretary of Health and Human Services for over fifteen years to adjudicate claims for child's disability benefits under the Supplemental Security Income (SSI) program established by Title XVI of the Social Security Act, 42 U.S.C. 1381 *et seq.* Those regulations are designed to give specific content to the statutory definition of "disability" as applied to individuals under age 18, which provides that such an individual shall be considered to be disabled if he suffers from an impairment that is of "comparable severity" to an impairment that would render an adult disabled. 42 U.S.C. 1382c(a)(3)(A). To implement that most general of statutory standards, the regulations at issue supplement the Listing of Impairments that the Secretary has found to be sufficiently severe for adults to preclude work activity (irrespective of vocational factors) with a special Listing of Impairments that applies only to individuals under age 18. This special supplementary Listing takes into account the par-

¹² The court of appeals also rejected respondents' contention that the Secretary did not fully comply with the requirements of Section 5(a) of the 1984 Act (see note 11, *supra*), because he revised the mental impairment criteria in the Part A Listing for adults but not in the Part B Listing for children. The court noted that there was no express reference in Section 5(a) to the Part B mental impairment criteria for children and that the purpose of the statutorily mandated revision, as set forth in Section 5(a) itself, was to assure that the "criteria and listings" "realistically evaluate the ability of a mentally impaired individual to engage in substantial gainful activity in a competitive workplace environment" (98 Stat. 1801)—a purpose that does not apply to children (Pet. App. 18a-19a).

ticular effects of disease processes in children and is designed to identify impairments that have an impact on a child's development that is comparable to the impact of impairments that would prevent an adult from engaging in substantial gainful activity.

This case involves a challenge to the facial validity of the Secretary's child disability regulations. Respondents contend, and the court of appeals held, that the Secretary may not rely on the Listing as the objective and uniform measure of the level of medical severity that children's impairments must meet or equal in order for them to be found disabled. Instead, they maintain, in *every* case in which a child does not have a medical condition of sufficient severity to meet or equal the Listing of impairments, the decision-maker must undertake an amorphous, case-by-case assessment of each child's residual abilities and unspecified non-medical factors that would be analogous to an adult claimant's vocational factors of age, education and work experience. This would occur despite the fact that the Secretary has already determined that the child does not have an impairment or a combination of impairments that would affect the child's development in a manner comparable to the effect of impairments on an adult's ability to work.

Since the only question before the Court concerns the facial validity of the Secretary's regulatory methodology, no question is presented concerning the adequacy of either Part A or Part B of the Listing of Impairments or the application of the Listing in particular cases. As the district court observed, "[i]f these criteria are being misapplied or misinterpreted, the remedy lies in the appeal process in individual cases, not in a class-action decree" (Pet. App. 24a). Nor is there any question before this Court as to whether particular amendments to the Part B Listing should be considered in the future (as they have been in the past) to take account of any additional impairments that may be shown by experience or medical advances to have the requisite impact on development in

children. The sole question to be decided is whether, no matter how exhaustive the Part A and Part B Listings of Impairments and their medical equivalents might be, the Secretary must nevertheless undertake an individualized assessment of a child's non-medical factors and residual functional capacity in order to satisfy the "comparable severity" standard of the statute.

The initial inquiry in answering this question, as the court of appeals recognized (Pet. App. 11a), is "whether Congress has directly spoken on the precise question at issue." See *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). The court of appeals concluded that Congress had in fact addressed this precise issue: if the Secretary undertakes an individualized assessment of vocational factors and residual functional capacity in cases involving adults, the court reasoned, then the Secretary must also undertake such an inquiry in cases involving children; otherwise, the Secretary will not be awarding benefits to children in all cases involving impairments of "comparable severity." This superficial analysis, however, overlooks a number of key features of the statutory language.

On the one hand, where Congress spoke of child's disability benefits—in the parenthetical clause at the end of paragraph (A) of 42 U.S.C. 1382c(a)(3)—it referred only to impairments of *comparable* severity, not *identical* severity. The use of the word "comparable" suggests a fairly wide range of latitude. Congress in this brief clause also spoke in terms of the degree of severity of the physical or mental impairment itself, not in terms of the regulatory method for ascertaining the existence of such an impairment. Thus, paragraph (A) cannot be read as an express mandate that the Secretary follow the same five-part sequential evaluation process with children as with adults. On the other hand, paragraph (B) of the statutory definition of disability, 42 U.S.C. 1382c(a)(3)(B)—which is the provision that mandates a case-specific inquiry into non-medical factors and re-

sidual functional capacity with respect to adults—makes no mention of children and includes no parenthetical comparability clause. This silence is significant, for if Congress had directly spoken to the issue, the most logical way to do so would be to include such a "comparability" clause in paragraph (B) analogous to the parenthetical clause that appears in paragraph (A).

It is also significant that the principle on which the Secretary's regulations are based—that a child will be found to be disabled only if his impairment meets or equals a listed impairment, taking into account special impacts of impairments on children—was embodied in the regulations promulgated by the Secretary at the outset of the SSI program in January 1974. Congress was apprised of this approach in 1976, and yet it adopted legislation directing the Secretary to publish the criteria for children that he had developed to implement that approach and that became Part B of the Listing of Impairments. This Court has observed that where Congress has been apprised of an agency's interpretation of a statute, and amends the statute in other respects, "then presumably the legislative intent has been correctly discerned." *United States v. Rutherford*, 442 U.S. 544, 554 n.10 (1979). That presumption of correctness applies *a fortiori* where, as here, Congress not only declines to overturn the agency's interpretation, but affirmatively directs the agency to take action that implements its interpretation.

Not only does the methodology embodied in the regulations represent a contemporaneous construction of the statute by the agency charged with implementing it, the Secretary has also consistently adhered to that approach in the adjudication of thousands of child's disability claims each year. Contemporaneous, longstanding and consistently maintained regulations are entitled to great deference. Indeed, other courts of appeals have sustained the Secretary's approach as a reasonable implementation of the statutory standard. See *Hinckley v.*

Secretary of HHS, 742 F.2d 19 (1st Cir. 1984); *Powell v. Schweiker*, 688 F.2d 1357 (11th Cir. 1982); *Wilkinson v. Bowen*, 847 F.2d 660, 661 (11th Cir. 1987); *Petroleoni v. Secretary of HHS*, No. 87-2021 (10th Cir. Oct. 26, 1988) (unpublished); cf. *Williams v. Bowen*, 859 F.2d 255, 260 (2d Cir. 1988); *Burnside v. Bowen*, 845 F.2d 587, 590-591 (5th Cir. 1988).¹³ The court below erred in holding that regulations so firmly grounded in statutory text and congressional intent and in the long-standing administration of the SSI program are wholly beyond the Secretary's authority.

Nor can it credibly be maintained that the Secretary's regulations are arbitrary and capricious. The criteria in the special Part B Listing for children in fact *do* take into account functional and developmental consequences of impairments and their impact on ability to do age-appropriate activities where those factors are germane to particular impairments. In other words, the considerations that respondents would require the Secretary to consider on an individualized basis were taken into account in the formulation of the Part B Listing in the first place. As a result, the criteria in the Listing *already* embody the level of impairment severity that, in the Secretary's judgment, has an impact on development in a child comparable to the impact of an impairment on an adult's ability to work.

Moreover, if the decision-makers in the state agencies and SSA were required to depart from the Listing for children on an individualized basis, their inquiry in thousands of cases annually would not be anchored in any objective benchmark for determining when a child's functional impairment is sufficiently severe that he should be

¹³ The question of the regulations' validity is also pending before the Eighth Circuit in *Nash v. Bowen*, No. 88-2542, in which oral argument was held on May 9, 1989, and before the Ninth Circuit in *Burt v. Bowen*, No. 88-3990, which has not yet been scheduled for oral argument. There are district court cases going both ways on the issue. Pet. App. 16a-17a nn.4, 5; Reply Br. 6 n.4.

considered disabled. For adults, the non-medical factors of age, education and work experience, which are specified in the Act itself, can be readily ascertained and quantified in each case, and the purpose of the inquiry—determining the claimant's ability to work—is objectively anchored. But children do not generally work, and are not ordinarily expected to work. Neither respondents nor the court of appeals have offered any analogue to work that could be applied to all children in an administratively feasible manner; certainly, no special benchmark for measuring the residual functional capacity of children has been specified by Congress. The difficulties and potential for disuniformity resulting from the uncharted inquiry mandated by the court of appeals would impose an unreasonable burden on the agency—a burden that cannot be justified on the basis of the slender statutory reed of the word “any” contained in Section 1382c(a)(3)(A).

ARGUMENT

THE SECRETARY'S REGULATIONS GOVERNING THE EVALUATION OF SSI CHILD'S DISABILITY CLAIMS ARE FULLY CONSISTENT WITH THE STATUTORY REQUIREMENT THAT A CHILD'S IMPAIRMENT BE OF “COMPARABLE SEVERITY” TO AN IMPAIRMENT THAT WOULD RENDER AN ADULT DISABLED

A. The Secretary Has Broad Authority to Issue Legislative Regulations to Implement the Statutory Standards of Disability

Like *Heckler v. Campbell*, 461 U.S. 458 (1983), and *Bowen v. Yuckert*, 482 U.S. 137 (1987), this case involves a facial challenge to regulations issued by the Secretary of Health and Human Services to implement the basic statutory definition of “disability” under the Social Security Act. Congress drafted the definition of disability in very general terms, and entrusted the Secretary to use his accumulated “experience and expertise” (*Weinberger v. Salfi*, 422 U.S. 749, 765 (1975)) to give it

particularized content. The regulations promulgated by the Secretary to implement these general guidelines play a critical role in the administration of what by all accounts is a massive program. The Social Security Administration (SSA) is "probably the largest adjudicative agency in the western world."¹⁴ Together with adjudicators in the state agencies, SSA must review more than 2 million claims for various categories of disability benefits annually under the Social Security Act. *Yuckert*, 482 U.S. at 153.¹⁵ In a program this vast and multifaceted, detailed implementing standards are essential to ensure uniformity and fairness of administration.

In developing and revising these implementing regulations, the Secretary relies upon his Department's extensive experience gained in administering the disability and related social-welfare programs. In particular, the Secretary draws upon the advice of physicians and other experts, the insights gained by the state disability agencies and his own ALJs and Appeals Council in their adjudication of thousands of claims raising similar issues, and the intimate familiarity of his Department with the constant evolution of the programs through a process of legislative and administrative oversight and amendment. The regulations at issue here are the considered product of that elaborate process. See pages 36-39, *infra*.

As the Court has recognized in rejecting facial challenges to other provisions of the Secretary's disability regulations, "Congress has 'conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the Act.'" (*Bowen v. Yuckert*, 482 U.S. at 145, quoting *Heckler v. Campbell*, 461

¹⁴ *Heckler v. Campbell*, 461 U.S. at 461 n.2, quoting J. Mashaw, et al., *Social Security Hearings and Appeals* at xi (1978).

¹⁵ The SSI children's disability program is itself of substantial proportions. We have been informed by SSA that as of March, 1989, there were 294,000 children receiving disability benefits under the program, and that approximately 40,000-45,000 children become newly eligible for child's disability benefits each year.

U.S. at 466, and *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981)). The Secretary's authority in this case, as in *Yuckert* and *Campbell*, derives in the first instance from 42 U.S.C. 405(a), as made applicable to the SSI program by 42 U.S.C. 1383(d)(1) (1982 & Supp. IV 1986). Section 405(a) provides that the Secretary "shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of [the Act], which are necessary or appropriate to carry out such provisions," and that he "shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder."

Congress made the delegation of authority to the Secretary even more explicit with respect to the very subject at issue here when it enacted Section 501(b) of the Unemployment Compensation Amendments of 1976 (1976 Act), Pub. L. No. 94-566, 90 Stat. 2685. Section 501(b) directed the Secretary, within 120 days after enactment of the 1976 Act, to "publish criteria to be employed to determine disability (as defined in [42 U.S.C. 1382c(3)(A)] of the Social Security Act) in the case of persons who have not attained the age of 18" (90 Stat. 2685). The regulations challenged by respondents, and invalidated by the court of appeals, were promulgated pursuant to this express directive in 1977. See pages 32-33, 38, *infra*.

This Court has repeatedly stressed that such regulations are subject to only a very narrow scope of review. Where, as here, an agency's regulations are challenged on the ground that they are inconsistent with the statute they implement, this Court's decision in *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), establishes a general two-part framework for analysis. "First, always, is the question whether Congress has directly spoken to the precise question at

issue." *Id.* at 842. This question must be answered by "employing traditional tools of statutory construction" (*id.* at 842 n.9), and, in particular, by examining "[t]he words, structure, and history" of the statutory provision in question. *NLRB v. United Food & Commercial Workers Union, Local 23*, 108 S. Ct. 413, 421 (1987); see also *INS v. Cardozo-Fonseca*, 480 U.S. 421, 446-449 (1987); *Young v. Community Nutrition Institute*, 476 U.S. 974, 980-981 (1986). If, however, the reviewing court determines that "Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." 467 U.S. at 843 (footnotes omitted).

The deference to agency views reflected in this framework applies with special force where, as in this case, Congress has explicitly delegated authority to an administrative agency to implement a general statutory mandate with specific regulatory standards. Indeed, when Congress has delegated legislative authority to an agency, step one of the *Chevron* inquiry is quickly answered: Congress could not harbor a specific intention on the precise question at issue and yet at the same time direct an agency to develop an answer to that question. As this Court has observed, "[i]n a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term." *Batterton v. Francis*, 432 U.S. 416, 425 (1977). This Court has accordingly indicated that the standards adopted by an agency pursuant to an express grant of rulemaking power are entitled to "legislative effect," and they are given controlling weight "unless [they are] arbitrary, capricious, or manifestly contrary to the stat-

ute.'" *Atkins v. Rivera*, 477 U.S. 154, 162 (1986), quoting *Chevron*, 467 U.S. at 844.¹⁶

As we shall now show, neither the court of appeals nor respondents have shown that the method adopted by the Secretary for determining whether children suffer from medical impairments of "comparable severity" to those which are disabling for adults is manifestly contrary to the statute. Nor have they shown in any way that the methodology embodied in the regulations at issue here is arbitrary or capricious. To the contrary, the regulations are based on a reasonable, contemporaneous, and longstanding interpretation and implementation of the statutory standard of "comparable severity."

B. Congress Has Not Addressed the Question of What Regulatory Method Should Be Used in Determining Whether Children Suffer from an Impairment of "Comparable Severity" to One That Would Be Considered Disabling for an Adult

1. The general definition of disability set forth in the Social Security Act provides that an otherwise eligible adult is entitled to SSI disability benefits "if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months" (42 U.S.C. 1382c(a)(3)(A)). Congress did not apply this same test

¹⁶ Accord *Yuckert*, 482 U.S. at 145, quoting *Campbell*, 461 U.S. at 466 ("Where, as here, the statute expressly entrusts the Secretary with the responsibility for implementing a provision by regulation, [a court's] review is limited to determining whether the regulations promulgated exceeded the Secretary's statutory authority and whether they are arbitrary and capricious."); *United States v. Morton*, 467 U.S. 822, 834 (1984) ("Because Congress explicitly delegated authority to construe the statute by regulation, in this case we must give the regulations legislative and hence controlling weight unless they are arbitrary, capricious, or plainly contrary to the statute.").

to claimants under age 18, however, for the obvious reason that most children, simply by reason of their youth, are unable to engage in "any substantial gainful activity." Instead, Congress inserted at the end of the general definition of disability in paragraph (A) the following clause: "(or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity)." Congress did not, however, define the critical term "comparable severity." The Act therefore leaves it to the Secretary to give content to that term pursuant to his "exceptionally broad authority" under 42 U.S.C. 405(a) and 1383(d)(1) (1982 & Supp. IV 1986) (see *Yuckert*, 482 U.S. at 145, quoting *Campbell*, 461 U.S. at 466), as augmented by the specific directive to the Secretary in Section 501(b) of the 1976 Act to "publish criteria to be employed to determine disability . . . in the case of persons who have not attained the age of 18."

Several features of the statutory language support the conclusion that Congress did not intend to require the Secretary to follow the same methodology for determining disability in children as is used with adults. First, Congress did not direct that the severity of impairments for adults and children be identical, only that they be "comparable." As the term is commonly used, "comparable" does not require complete similarity. Rather, the term connotes circumstances "permitting or inviting comparison[,] often in one or two salient points only" (*Webster's Third New International Dictionary* 461 (1976)). Comparison "invites an examination of differences as well as resemblances." *DeJesus v. Perales*, 770 F.2d 316, 324 (2d Cir. 1985), cert. denied, 478 U.S. 1007 (1986). And the concept of comparability does not rigidly require uniformity insofar as the subjects to be compared "are different in a fundamental way." *Atkins v. Rivera*, 477 U.S. at 164 n.8. Accordingly, the central statutory term—"comparable severity"—is most reason-

ably interpreted as contemplating that the Secretary will take account of the differences as well as the similarities in children and adults. The Secretary has done exactly that, by following an essentially identical procedure for adults and children, except for an individualized consideration of non-medical factors and residual functional capacity which the Secretary has determined cannot be applied to children in a meaningful or administratively feasible manner.

Second, although the text of paragraph (A) prescribes a test for adults that focuses on the consequences of the impairment, i.e., whether the claimant is unable to engage in substantial gainful activity "by reason of" the impairment, the parenthetical reference to children does not expressly mention or even allude to consequences. By its terms, the statute's reference to children focuses exclusively on the existence of a "medically determinable physical or mental impairment" of the requisite degree of severity ("comparable"), not on whether the child personally retains the residual ability, despite the impairment, to perform "substantial gainful activity" or some other "activity" that is appropriate for children in general or children of the claimant's age in particular.

Third, the pivotal term "severity" has been used by the Secretary and Congress under the Social Security disability programs to refer to a *medically* severe impairment, the degree of which is based on medical evidence alone. This Court recognized as much in *Yuckert*, where it sustained the Secretary's regulation requiring an adult claimant to show at step two of the sequential evaluation process that his impairment satisfies a threshold level of "severity." The majority in *Yuckert* specifically rejected the dissent's proposal to "make the severity of the claimant's *medical* impairment turn on *nonmedical* factors such as education and experience" (482 U.S. at 149 n.7 (emphasis in original)). That usage is also reflected in Section 4(a)(1) and (b) of the Social Secu-

rity Disability Benefits Reform Act of 1984, 98 Stat. 1800, which ratifies the severity regulation by referring to the threshold test of whether the claimant's impairment is of sufficient "medical severity" (42 U.S.C. 1382c(a)(3)(F) (Supp. IV 1986) quoted in *Yuckert*, 482 U.S. at 150). See also 482 U.S. at 151-152 (discussing legislative history of 1984 Act referring to determinations of severity based on medical evidence alone, without consideration of age, education, and work experience).¹⁷ The Secretary's regulations for determining child's disability define "comparable severity" in a similar manner: they provide that the "severity" of a child's impairment is to be based on medical factors and evidence alone, without individualized consideration of vocational or similar non-medical factors (or, therefore, of the claimant's RFC).¹⁸ The regulations under challenge are therefore supported by Congress's use of the term "severity" in 42 U.S.C. 1382c(a)(3)(F) (Supp. IV 1986) and elsewhere in the Social Security Act.

Fourth, none of the language in paragraph (A) of Section 1382c(a)(3) suggests that because the Secretary chooses to adopt a particular method for determining disability in adults based on a sequential evaluation process, he must do so for children, and in the process incorporate a consideration of factors akin to an adult's age, education, work experience and RFC. Specifically, Section 1382c(a)(3)(A) does not require the Secretary to use the "same methodology" for both children and adults.

¹⁷ See also 482 U.S. at 148, quoting S. Rep. 744, 90th Cong., 1st Sess. 48-49 (1967) (claimant is disabled "only if it is shown that he has a severe medically determinable physical or mental impairment or impairments").

¹⁸ Of course, the determination of what kinds of physical or mental impairments will be regarded as severe is based on the impact of the impairment on development in children, just as the regulation at issue in *Yuckert* measured the severity of an impairment in terms of whether it substantially limits the claimant's ability to do basic work-related activities. See 482 U.S. at 141, 146.

Compare 42 U.S.C. 1396a(a)(10) (1982 & Supp. IV 1986), discussed in *Atkins v. Rivera*, 477 U.S. at 158. It requires only that a child's impairment be of "comparable severity" to that which would cause an adult to be considered disabled.

Finally, the fact that the parenthetical reference to children in 42 U.S.C. 1382c(a)(3)(A) speaks of "any" physical or mental impairment does not detract from the discretion conferred by the general term "comparable severity." The court of appeals seized on Congress's use of the word "any," observing that "Congress has expressed unambiguously its intent that 'any' impairment which meets the statutory standard shall be found disabling" (Pet. App. 11a). That is true; but it begs the question at issue: What is the statutory standard applicable to children? Congress simply did not say. It chose, rather, to leave the term, "comparable severity," undefined. Of course, within the regulatory framework established by the Secretary, "any" impairment that satisfies the prescribed standards—i.e., any impairment that meets or equals an impairment in the adult Listing or the special children's Listing—renders a child eligible for benefits. That result fully satisfies the statutory language upon which the court of appeals relied.¹⁹

¹⁹ Respondents argue (Br. in Opp. 20-22) that the Secretary's regulations are inconsistent with Sections 4(b) and 9(b)(1) of the Social Security Disability Benefits Reform Act of 1984, 42 U.S.C. 1382c(a)(3)(F) and 423(d)(5)(B) (Supp. IV 1986). The latter requires the Secretary to consider all evidence in the claimant's case record, and the former requires the Secretary to consider the combined effect of several impairments at each step of the sequential evaluation process. See *Yuckert*, 482 U.S. at 149-152. Respondents' reliance on the 1984 Act is misplaced. Section 9(b)(1) does not modify any substantive standards of disability; it is concerned only with the evidence on which a decision under those standards must be made. As the court of appeals recognized (Pet. App. 17a-18a), Section 4(b) likewise lends no support to respondents' position. Even before the 1984 Act was passed, Social Security Ruling

2. The conclusions drawn from consideration of the language of paragraph (A) of 42 U.S.C. 1382c(a)(3)—that Congress left the method of determining comparable severity to the Secretary and that the method chosen by the Secretary is fully consistent with the statute—finds further support in paragraph (B) of that provision. Paragraph (B) contemplates, in the case of an adult claimant, that the Secretary will engage in an individualized inquiry into whether “his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy” (42 U.S.C. 1382c(a)(3)(B)).²⁰ But paragraph (B) does not identify any non-medical factors that must be considered on an individual-

(SSR) 83-19 provided that the combined impact of several impairments could be considered in determining whether a claimant's impairments equalled the listings. See J.A. 239. That requirement is carried forward under current regulations. See 20 C.F.R. 416.923 (stating that the combined effect of multiple impairments will be considered “throughout the disability determination process”); 20 C.F.R. 416.926(a) (explaining the method for determining whether a claimant's “impairment(s) is medically equal to a listed impairment”). In light of these regulatory provisions and SSR 83-19, respondents err in contending (Br. in Opp. 8, 21) that the Listings do not allow for consideration of the combined effect of multiple impairments. The 1984 Act therefore casts no doubt on the Secretary's longstanding approach to evaluating claims for child's disability benefits, and respondents in fact point to no evidence of congressional intent in 1984 to mandate a change in that approach.

²⁰ This inquiry is required only if the claimant's impairment satisfies the threshold level of severity that is applied at step two of the sequential evaluation process for adults. See *Yuckert*, 482 U.S. at 148-149. Even so, 42 U.S.C. 423(d)(2)(A), after which 42 U.S.C. 1382c(a)(3)(B) was patterned, was enacted in 1967 as part of amendments designed to “reemphasize the predominant importance of medical factors in the disability determination.” *Yuckert*, 482 U.S. at 148, quoting S. Rep. No. 744, 90th Cong., 1st Sess. 48 (1967).

ized basis in children in the same manner that an adult claimant's age, education, and work experience are taken into account. Nor does paragraph (B) direct that the functional abilities of the child (notwithstanding the impairment) be considered on an individualized basis in children in a manner that is analogous to the individualized consideration (by use of the RFC assessment) with respect to an adult claimant's ability to work. It does not, for example, require an individualized inquiry into whether the child retains the residual ability to perform “age-appropriate” activities, as respondent suggests (Br. in Opp. 28).

Perhaps most significantly, paragraph (B) of Section 1382c(a)(3), unlike paragraph (A), has no parenthetical “comparability” clause. The presence in paragraph (B) of such a clause (providing for “comparable” treatment) might have been understood to require the sort of parallel that respondents and the court below urge between the disability determination process for children and the individualized assessment of an adult claimant's vocational factors and residual ability to work. The absence of such a clause, by contrast, substantially undercuts that position, for “[i]n the context of the statute's precisely drawn provisions, this omission provides persuasive evidence that Congress deliberately intended” not to require a “comparabl[y]” individualized consideration of residual abilities and non-medical factors. *United States v. Erika, Inc.*, 456 U.S. 201, 208 (1982); see also *United States v. Fausto*, 108 S. Ct. 668, 673 (1988); *Block v. Community Nutrition Institute*, 467 U.S. 340, 347 (1984).

The legislative history likewise suggests the deliberate nature of paragraph (B)'s omission of any reference to children. In describing this provision, the House Report explicitly noted that the inquiry into the claimant's ability to work—and therefore into the effect that his age, education and work experience might have on his ability to work—should not be conducted in the case of children. The House Report explained:

an individual (*other than a child under age 18*) [will be determined to be under a disability only if his physical or mental impairment or impairments are of such severity] * * * that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work * * *.

H.R. Rep. No. 231, 92d Cong., 1st Sess. 148 (1971) (emphasis added). This legislative history, albeit terse, tends to support the proposition that if Congress harbored any specific intention on the question presented, it was that an individualized assessment of non-medical factors and functional capacity was *not* required with respect to children.

3. We also think it significant that Congress was made aware of the Secretary's general approach to child's disability benefits in 1976; yet, far from disapproving that approach, Congress responded with legislation mandating that the Secretary "publish" his criteria that implemented that approach. This legislation, adopted not long after enactment of the original SSI program in 1972 (and coming close on the heels of the adoption of the Secretary's original regulations in 1974), strongly suggests that Congress (at least the Congress of 1976) perceived no conflict between the Secretary's approach and the statute. As this Court has observed, "it may not always be realistic to infer approval of a judicial or administrative interpretation from congressional silence alone. * * * But once an agency's statutory construction has been 'fully brought to the attention of the public and the Congress,' and the latter has not sought to alter that interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned." *United States v. Rutherford*, 442 U.S. 544, 554 n.10 (1979) (citations omitted). See also *North Haven Board of Education v. Bell*, 456 U.S. 512, 535 (1982); *CBS, Inc. v. FCC*, 453 U.S. 367, 382 (1981).

As discussed more fully below (see pages 36-38 *infra*), the Secretary's method of adjudicating child's disability claims without any individualized consideration of vocational or other non-medical factors was fully formed in 1974. On January 11, 1974, the Secretary published for comment the proposed regulations governing determinations of disability under the SSI program, which had just gone into effect on January 1, 1974. See 39 Fed. Reg. 1624 (1974). Those regulations provided that disability "shall be deemed to exist for a child under age 18" if (1) he is not engaged in substantial gainful activity, (2) his impairment meets the durational limitations for adults, and (3) his impairment is included in the Listing in Appendix 1, or, if not listed, "is determined by the [Social Security] Administration, with appropriate consideration of the particular effect of disease processes in childhood, to be medically the equivalent of a listed impairment" (39 Fed. Reg. 1626 (1974), adding 20 C.F.R. 416.904). After receiving and reviewing public comments, the Secretary published the regulations in final form on July 29, 1975. 40 Fed. Reg. 31,778, 31,783 (1975).

Contemporaneously with the publication of the proposed regulations, SSA sent Supplement 1 to Disability Insurance Letter III-11 to the state agencies on January 9, 1974, in an effort to elaborate on the guidance necessary for them to begin the adjudication of claims. See J.A. 94-114. The supplementary letter noted that the proposed regulations "specifically require[] that a child's impairment or impairments must either *meet or equal* the listing of impairments which will be published in an appendix" (J.A. 95 (emphasis in original)). It accordingly furnished materials to assist the recipient agencies in determining which criteria in the adult Listing could be used in evaluating children (J.A. 101-103), as well as a list of "childhood impairment guides" to assist in determining whether a child's impairment was equivalent in severity to a listed impairment, taking into account

special considerations in children (J.A. 104-114). Those informal "guides" described impairments "the impact of which will interfere with the child's major activities (i.e., growth and development) to the same extent as the impact of the impairments listed in the adult criteria interfere with the adult's ability to engage in substantial gainful activity" (J.A. 97). It was expected that after sufficient experience had been gained in applying the guides and supplemental criteria were developed, they would be published in the regulations themselves as part of a separate Listing applicable to children (J.A. 95).

After some delay in developing published criteria, several state agencies and other interested groups expressed concern to Congress during its oversight of the commencement of the SSI program that SSA had not issued more specific or definitive guidelines to implement the general principles embodied in the regulations. See S. Rep. No. 1265, 94th Cong., 2d Sess. 24-25 (1976).²¹ In the legislative deliberations that followed, and ultimately resulted in the enactment of Section 501(b) of the Unemployment Compensation Amendments of 1976, there can be no doubt that Congress was fully apprised of the Secretary's methodology.²² As the Senate Report on the 1976 Act recognized, quoting the central regulatory provision, "[t]he regulations which have been issued

²¹ See also *Supplemental Security Income Program: Hearings Before the Subcomm. on Public Assistance of the House Comm. on Ways and Means*, 94th Cong., 1st Sess. 329, 349, 354, 363-364, 520, 535, 538, 541, 548, 781-782 (1975) [hereinafter *1975 Hearings*].

²² During oversight hearings on the SSI program in 1976, the Commissioner of Social Security summarized the use of the informal guides and evaluation concepts to adapt the adult Listing to children, and noted that he had sent a letter to the House Subcommittee on Public Assistance in July 1975 explaining SSA's approach. *Oversight of the Supplemental Security Income Program: Hearings Before the Subcomm. on Oversight of the House Comm. on Ways and Means*, 94th Cong., 2d Sess. 21-22 (1976); see also *1975 Hearings* at 781-782.

with regard to disability for children state that if a child's impairments are not those listed, eligibility may still be met if the impairments 'singly or in combination . . . are determined by the Social Security Administration, with appropriate consideration of the particular effect of the disease processes in childhood, to be medically the equivalent of a listed impairment.' " S. Rep. No. 1265, *supra*, at 24. Section 501(b) of the 1976 Act did not question that basic approach. To the contrary, it was intended to ensure that the Secretary adopt without further delay more specific or definitive guidelines to implement the general principle of medical equivalence embodied in the regulations. S. Rep. No. 1265, *supra*, at 24-25. The Senate Report recognized the difficulty of developing "objective criteria" for determining how to apply the disability definition to children; but the Committee perceived a need for uniform guidance, and it noted that "SSA ha[d] been circulating draft regulations with criteria for child disability for some time" (*id.* at 25). The Senate Report also stated that the legislation was designed to "end the present uncertainty which the State agencies and others have with regard to what constitutes disability in a child." *Ibid.* The Secretary published for comment SSA's draft regulations and implementing criteria only three months after the 1976 Act was passed (41 Fed. Reg. 53,042 (1976)), and published them in final form two months later (42 Fed. Reg. 14,705 (1977)).

This history cannot be squared with the court of appeals' conclusion that the Listing approach embodied in the regulations published both before and after the 1976 Act was passed is "manifestly contrary" to the Act (*Chevron*, 467 U.S. at 844) and that Congress specifically intended to require the Secretary to engage in an individualized consideration of vocational factors or other non-medical factors and RFC in determining a claimant's eligibility for child's disability benefits. To the contrary, the ad hoc approach respondents advocate would,

if anything, be contrary to the 1976 Act's purpose of requiring the Secretary to furnish the States with objective standards to assure uniform administration.²³

Moreover, Congress has never expressed disagreement with the manner in which the Secretary has implemented the child's disability program. Without suggesting any authoritative dimension to these materials, we note that in a report on the SSI program published soon after the regulations were promulgated in 1977, the Senate Finance Committee Staff noted the publication of the regulations without questioning their validity, observing that "[t]he nonmedical vocational factors were not applied to the children for basically the same reasons they had not been applied to disabled widows in earlier legislation, i.e., that as a group they had not had enough attachment to the labor force to make application of the factors feasible." Staff of Senate Comm. on Finance, *Report on SSI Program*, 95th Cong., 1st Sess. 125 (Comm. Print 1977). Again in 1979, the Senate Finance Committee Staff noted that the child's disability regulations published in March 1977 "were those needed to implement the childhood disability provisions of the SSI program." Staff of Senate Comm. on Finance, *Report on Issues Related to Social Security Act Disability Programs*, 96th Cong., 1st Sess. 20 (Comm. Print 1979). Our point is this: the manner in which the Secretary has implemented the "comparable severity" standard in 42 U.S.C. 1382c(a)(3)(A) has been brought to Congress's attention on a number of occasions. But despite comprehensive congressional oversight of the SSI program and the standards for determining disability (see, e.g., *Schweiker*

²³ The House passed a bill in 1976 that likewise would have mandated the adoption of regulatory criteria for children, but would have expressly required the regulations to include "medical, social, personal, educational, and other criteria." 122 Cong. Rec. 27,853 (1976). Significantly, the provision Congress enacted as Section 501(b) of the 1976 Act did not include the quoted language.

v. Chilicky, 108 S. Ct. 2460, 2469 (1988); *Heckler v. Day*, 467 U.S. 104, 111-118 (1984)), including the extensive amendments made by the Social Security Disability Benefits Reform Act of 1984, Congress has never drawn into question, much less altered, the Secretary's regulatory approach.

C. The Child's Disability Regulations Are Based on a Contemporaneous and Longstanding Interpretation of the Statutory Standard That Is Both Reasonable and Fully Consistent with the Purposes of the Act

1. The Secretary's Regulations Reflect a Longstanding and Contemporaneous Construction of the Act That Has Been Consistently Maintained for Over Fifteen Years

This Court has emphasized on many occasions that administrative regulations are entitled to special deference where they "represent[] 'a contemporaneous construction of a statute by the men charged with the responsibility of setting its machinery in motion, of making the parts work efficiently and smoothly while they are yet untried and new.'" *Aluminum Co. of America v. Central Lincoln People's Utility District*, 467 U.S. 380, 390 (1984), quoting *Udall v. Tallman*, 380 U.S. 1, 16 (1965). Compare *Public Citizen v. Department of Justice*, No. 88-429 (June 21, 1989), slip op. 23 n.12. The Court has also held on many occasions that "longstanding" regulations that have been consistently maintained are entitled to comparatively greater deference than regulations that are relatively recent or have frequently been changed. See, e.g., *FEC v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 32-38 (1981); *Udall v. Tallman*, 380 U.S. at 16-17. Each of these descriptions applies with full force to the regulations at issue here: they were adopted contemporaneously with the implementation of the child's disability program; they have been in effect in their present form for over fifteen years; and they have been consistently maintained in that form throughout this lengthy period.

The regulatory methodology now drawn into question is the product of the exercise by the Secretary of his considered judgment, at the very outset of the SSI program, under the statutory grants of authority in 42 U.S.C. 405(a) and 1383(d)(1). It was adopted only after thorough study of the legal issues; consultation with medical and other experts; assessment of the Department's extensive experience in making disability determinations under the Title II insurance program during the preceding 18 years; utilization of notice-and-comment rulemaking procedures; and congressional oversight and approval.

As noted above (see page 33, *supra*), the Secretary's basic approach to evaluation of child's disability claims was promulgated in formal regulations published in 1977. That approach was first articulated, however, in 1973 in SSA Disability Insurance Letter No. III-11 (J.A. 89-93). DIL III-11 was sent to state agencies responsible for disability determinations on September 7, 1973, during the period that Congress afforded the Secretary to prepare for the commencement of the SSI program on January 1, 1974.²⁴ The Letter explained the basic rationale for the approach SSA planned to pursue (and has pursued ever since) (J.A. 90-91 (emphasis in original)):

Historically, the term "disability" has, under title II, been associated exclusively with an inability to work, which is the primary activity of adults. This term, when applied to children, cannot properly be associated with an inability to work, since children

²⁴ SSA observed that with the impending implementation of the SSI program, it would be responsible for the first time for evaluating children under the age of 18, and that there was no organization known to exist that had a large scale program involving this type of disability evaluation. For this reason, SSA explained, evaluation criteria would be based on: "(1) experience drawn from the title II disability program insofar as it may relate to children; and (2) expertise provided by medical authorities, particularly by experts in the field of childhood diseases and impairments" (J.A. 89).

are not ordinarily expected to engage in such activity. Accordingly, disability in children must be defined in terms of the primary activity in which they engage, namely growth and development, the process of maturation. Additionally, * * * the impact of the disease may be quite different [in children]. * * *

These factors make it impossible to compare directly the severity of the child's impairment with that of an impairment which would prevent an adult from engaging in SGA [substantial gainful activity]; thus, in applying the guides, "comparable severity" means that the severity of the impact of the child's impairment(s) must be "comparable" to the severity of the impact of an impairment(s) which would prevent an adult from engaging in any substantial gainful activity. In applying this concept to adjudication, childhood disability will be determined solely in consideration of medical factors.

DIL III-11 further explained that "[v]ocational factors will not be considered in the evaluation of childhood disability," because "[t]he application of such factors would be inappropriate since the primary activities of children are not generally measured in vocational terms" (J.A. 91 (emphasis in original)).

In addition, the state agencies were informed that the Listing of Impairments (used to evaluate adult disability claims under Title II solely on the basis of medical factors) would be utilized to the extent feasible to evaluate SSI child's claims as well. However, SSA recognized that some of those listings would be inappropriate to use in evaluating children, and it stated that supplementary guides would be issued to explain how the Title II Listing for adults, including the concept of medical equivalence, would be adapted to the special circumstances of the child's disability program. SSA also stated that after it carefully analyzed the adjudicative experience with these guides, "[p]ermanent evaluation criteria will be formally issued at a later date" (J.A. 92).

Thus, the basic contours of the approach to evaluating claims for child's disability benefits were in place before the SSI program even went into effect on January 1, 1974. That approach embodied the essential elements of the child's disability program as it exists today: determinations based on medical factors alone, measuring the severity and impact of the impairment itself; use of the Listing for that purpose; identification of criteria under the Listing on the basis of a legislative-type assessment of each listed impairment's impact on a child's development; and no individualized consideration of vocational or other non-medical factors (or, therefore, of RFC).

As the Secretary contemplated in 1974 (and as Congress specifically directed in 1976), the special medical criteria against which a child's impairments are to be measured were subsequently elevated to the form of a supplemental Listing. The Listing also incorporated additional and more detailed criteria based on the accumulated experience gained during the first several years of the SSI child's disability program. The regulations were proposed on December 3, 1976 (41 Fed. Reg. 53,042) and were formally adopted on March 16, 1977 (42 Fed. Reg. 14,705).

Those regulations retained the general standards of disability for children that were contained in 20 C.F.R. 416.904 (1976), including the general requirement that a child's impairment must meet a listed impairment or be "determined by the Social Security Administration, with appropriate consideration of the particular effect of disease processes in childhood, to be medically the equivalent of a listed impairment" (42 Fed. Reg. 14,707-14,708 (1977)). But in order to furnish more specific guidance, the regulations added a new Part B to the Appendix of listed impairments (42 Fed. Reg. 14,708 *et seq.* (1977)), which contained "[a]dditional medical criteria" for the evaluation of children where the criteria in Part A do not give appropriate consideration to the "particular

disease process in children" (*id.* at 14,708). The Secretary made clear in the preamble to these regulations, however, that the special criteria in the Part B Listing did not contain new *substantive* standards, but rather were intended to "clarify existing adjudicative guides" (those previously furnished by SSA in DIL III-11 and supplements thereto) and to "facilitate the decision making process" by furnishing specific criteria directly applicable to children. *Id.* at 14,705. As a result, the Secretary stressed, "determinations of disability of children . . . have been made and will continue to be made under the authority provided in [20 C.F.R.] 416.904 and in consideration of the basic requirements stated therein" (*ibid.*), which include the requirement that the impairment meet or equal the Listing.

The preamble to the final regulations explained that the special medical criteria for children "were developed and formulated over a 2-year period by the Social Security Administration Medical Consultant Staff together with practicing physicians, and other professionals, such as psychologists, who are experts in various specialties, primarily pediatrics," and that "[s]everal groups in the medical community were requested to comment on those medical criteria as they were being formulated" (42 Fed. Reg. 14,705 (1977)). The preamble further explained that in identifying impairments and the level of severity that would establish disability, "these professionals placed primary emphasis on the effects of physical and mental impairments in children, the impact of the impairment on the child's activities, and the restrictions on growth, learning, and development imposed on the child by the impairments. Those impairments which were determined to impact on the child's development to the same extent that the adult criteria have on an adult's ability to engage in substantial gainful activity were deemed to be of 'comparable severity' to the adult listing." All the listed impairments have a disabling impact on the child's development in one form or another—physical, mental, emotional, or social. *Id.* at 14,705-14,706.

In response to comments, the preamble to the final regulations also specifically addressed several of the considerations respondents now raise. First, in response to a comment that SSA "interprets severity [of an impairment] in medical rather than functional terms," the Secretary explained that that interpretation was necessitated by 42 U.S.C. 1383c(a)(3)(C), which specifies that a physical or mental impairment be one that is "demonstrable by medically acceptable clinical and laboratory diagnostic techniques." At the same time, the Secretary noted that the new medical criteria in the regulations "do result in functional limitations or restrictions, depending on the nature of the impairments, and these have been considered." 42 Fed. Reg. 14,706 (1977).

Second, the Secretary pointed out that the approach for evaluating children is flexible, explaining that the listed impairments "provide a means to efficiently and equitably evaluate the more common impairments" and also allow a claimant to establish eligibility by showing that he has an impairment or combination of impairments that are medically equivalent to a listed impairment. 42 Fed. Reg. 14,706 (1977).

Third, in response to comments that the regulations should be broadened to include developmental needs, the Secretary noted that the medical criteria in the Listing "do consider developmental levels" and that "[m]any of the criteria were established by considering disability in terms of departures from developmental norms at various levels." 42 Fed. Reg. 14,706 (1977). These criteria take into account physical, mental, and emotional development, and incorporate developmental milestones where they apply. *Ibid.* By the same token, the Secretary explained that developmental needs—e.g., counseling, special education, training, rehabilitation, and guidance—are not considered as such, "because they are not within the scope of the law." *Ibid.*

Fourth, the Secretary rejected the proposition that a child be denied benefits if he actually performs age-

appropriate activities, just as an adult is denied benefits if he is actually engaged in substantial gainful activity. He explained that such a standard for all impairments would be "unduly restrictive and not within the intent of the law." 42 Fed. Reg. 14,706 (1977).

As the foregoing discussion makes clear, the Secretary's construction of the "comparable severity" standard in 42 U.S.C. 1382c(a)(3)(A) to permit the regulatory approach that the court of appeals invalidated on its face was adopted at the very outset of the SSI program and reaffirmed in greater detail in light of initial experience under the programs (and consideration of issues very similar to those now raised by respondents). This long-standing and consistently maintained interpretation of the statute is entitled to great deference.

2. The Secretary's Methodology for Adjudicating Child's Disability Cases Is Reasonable and Consistent with Congress's Purposes In Extending SSI Disability Benefits to Children

For the reasons given by the Secretary both in adopting his regulatory approach to children's disability benefits in 1973 and in reaffirming that approach when formal regulations augmenting the Listing were promulgated in 1977, it can scarcely be maintained that the methodology chosen to implement the statutory directive is "arbitrary, capricious, or manifestly contrary to the statute." *Atkins v. Rivera*, 477 U.S. at 162; see *Yuckert*, 482 U.S. at 145.

The court of appeals faulted the Secretary's regulations as "too restrictive" because they did not afford children "the opportunity for individual evaluations comparable to the residual functional capacity assessment for adults." Pet. App. 16a, 17a. This concern is misguided. The regulations *do* require that each child who applies for benefits be evaluated on an individualized basis. The regulations provide for an individualized assessment by allowing each child to establish the severity of his own impairment and to qualify for benefits by showing that

his impairment meets or exceeds any impairment listed in either Part A or Part B of the Listing or is the medical equivalent of any such impairment. See *Hinckley*, 742 F.2d at 23.

Nor is it true, as the court below surmised, that the child's disability regulations are divorced from functional considerations. To the contrary, some of the criteria in Part B explicitly call for an assessment of a child's functional capacity where such an assessment is relevant in measuring the severity of the impairment. See, e.g., 101.03(C) ("[i]nability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene"); 111.06 ("Persistent disorganization or deficit of motor function . . . which . . . interferes with age-appropriate major daily activities"); 112.03 (psychosis resulting in "marked restriction in the performance of daily age-appropriate activities . . . [and] deficiency of age-appropriate self-care skills"). The regulations focus, however, not on the individual child's ability to function as such, but on the impact of the impairment on his physical, mental, and emotional growth and development. An assessment of functional abilities will normally be subsumed in applying these standards. Moreover, as noted above, if, as respondents allege, there are any "gaps" in the Secretary's Part B Listing (Br. in Opp. 24)—that is, if experience reveals that the Listing overlooks certain impairments that have a severe impact on childhood growth and development, or inadequately gauges the impact of a specific impairment on childhood development—the solution is not to jettison the entire regulatory framework. Rather, as the district court observed, the proper remedy is to challenge particular Part B listings (or the absence of such listings) on judicial review of the denial of disability benefits.

The Secretary's decision not to provide for an individualized assessment of a child's residual functional capacity is also supported by powerful practical consider-

ations. Simply put, an assessment of residual functional capacity or functional impairment cannot exist in a vacuum. The relevant question is, functional capacity to do *what*? With respect to adults, the Secretary is instructed to inquire into an individual's functional capacity to engage in "substantial gainful activity," i.e., to work. Ability to work thus provides a single, objective benchmark against which a person's individual non-medical attributes—his age, education, and previous work experience—can be assessed. As the Secretary has recognized from the outset of the program, however, the assessment of disability in children "cannot properly be associated with an inability to work, since children are not ordinarily expected to engage in such activity." J.A. 90.

Although the court of appeals would require the Secretary to make "individual evaluations comparable to the residual functional capacity assessment for adults" (Pet. App. 17a), it offered no suggestion as to how this was to be done. A case-by-case evaluation of whether a child, if he were an adult, would be disabled, would be wholly unworkable. Adults are evaluated on the basis of their age, education and work experience. If this process were extended to children, how old, how educated, and how experienced should the "hypothetical" adult be? It is also significant that if an adult is considered disabled only because one or more of these vocational factors is adverse—i.e., the claimant is of or approaching advanced age, is relatively lacking in education, or does not have work experience that is readily transferable to other jobs—the basis of his disability is not the "severity" of the impairment standing alone, but the impairment plus one or more other factors that are irrelevant for children. Put another way, the impairment of such an adult is not one that would in itself render *all* adults disabled, and it therefore is not one that attains the level of severity to which the impairments in *all* children can meaningfully be compared.

If, as the Secretary firmly believes, the ability-to-work criterion specified by Congress for use with adults cannot be applied directly to children, there is no analogous benchmark that can feasibly be adopted for use with children. Virtually any substitute formulation, for example, ability to engage in "age-appropriate activities" (Br. in Opp. 28), would be so amorphous that it would provide, at best, a fertile field for disagreement among experts. It would manifestly not provide a workable standard suitable for application in thousands of individual disability adjudications.²⁵ Moreover, any such substitute formulation would have no foundation in the text of the statute. If Congress intended to require an individualized assessment of functional capacity in children's disability cases (and for the reasons discussed above, we believe it did not), Congress paid no attention at all to the need for an appropriate and workable benchmark to orient that inquiry. The complete absence of congress-

²⁵ There is thus no contradiction between the fact that the Secretary has taken functional considerations into account in developing the Part B Listing, and yet has declined to direct adjudicators to make an assessment of residual functional capacity or other non-medical factors with respect to children on a case-by-case basis. The development of the special Listing involves precisely the type of generalized inquiry where conflicting views of medical and psychological experts can be weighed and sifted, and an informed judgment can be reached as to the most likely impact of any given impairment in the typical case. This process, which involves multiple layers of review and can be quite time-consuming, results in the development of a standard (a new or revised Listing) which can then be applied in individual cases. In the context of an individual adjudication, in contrast, it would be necessary to take extensive evidence and develop a considerable record *both* to determine the relevant standard (what sorts of activities would be appropriate for a child of a given age and background) *and* to determine whether the particular claimant satisfied that standard. To require the Secretary to resolve these issues "at each hearing would hinder needlessly an already overburdened agency." *Campbell*, 461 U.S. at 468.

sional guidance on this question strongly supports the Secretary's decision to forgo any such inquiry.

More generally, the Secretary's regulatory approach accords with the different purposes underlying the disability programs for adults and children. The purpose of disability benefits for adults is to ensure "the basic means of replacing earnings that have been lost as a result of . . . disability" for those who "are not able to support themselves through work . . ." H.R. Rep. No. 231, *supra*, at 146-147. For this reason, insofar as adults are concerned, "[t]he Social Security Act defines 'disability' in terms of the effect a physical or mental impairment has on a person's ability to function in the workplace." *Heckler v. Campbell*, 461 U.S. at 459-460 (interpreting identical definition of disability in 42 U.S.C. 423(d)(2)(A)). In light of this purpose, it is appropriate for adults to be evaluated not only in terms of the severity of their impairment but also in terms of their residual functional capacity to perform work.

By contrast, Congress had a different set of considerations in mind in providing for children's SSI benefits. Recognizing that disabled children from low-income households are "among the most disadvantaged of all Americans," Congress thought that special disability benefits would be appropriate for such children "because their needs are often greater than those of nondisabled children." H.R. Rep. No. 231, *supra*, at 147-148. In other words, the aim of Congress in establishing children's disability was not to replace lost income, but to provide for the special health care needs of disabled children, such as home health care expenses arising out of a child's medical impairment. It is entirely consistent with this quite distinct purpose to focus consideration on the severity of the child's impairment from a medical perspective alone, without individualized consideration of vocational or similar factors or the claimant's residual functional capacity. A child's special needs will of neces-

sity be determined by the nature and severity of his impairment, not by his ability to contribute to the family's income.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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APPENDIX

STATUTORY AND REGULATORY PROVISIONS INVOLVED

1. Section 1614(a)(3)(A) of the Social Security Act, as codified at 42 U.S.C. 1382c(a)(3)(A), provides:

An individual shall be considered to be disabled * * * if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

2. Section 1614(a)(3)(B) of the Social Security Act, as codified at 42 U.S.C. 1382c(a)(3)(B), provides in pertinent part:

For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy * * *.

3. Section 501(b) of the Unemployment Compensation Amendments of 1976, Pub. L. No. 94-566, 90 Stat. 2685, provides:

Publication of Criteria.—The Secretary shall, within 120 days after the enactment of this subsection, publish criteria to be employed to determine disability (as defined in section 1614(a)(3) of the Social Se-

curity Act) in the case of persons who have not attained the age of 18.

4. 20 C.F.R. 416.924 provides:

We will find that a child under age 18 is disabled if he or she—

(a) Is not doing any substantial gainful activity; and

(b) Has a medically determinable physical or mental impairment(s) which compares in severity to any impairment(s) which would make an adult (a person age 18 or over) disabled. This requirement will be met when the impairment(s)—

(1) Meets the duration requirement; and

(2) Is listed in Appendix 1 of Subpart P of Part 404 of this chapter; or

(3) Is determined by us to be medically equal to an impairment listed in Appendix 1 of Subpart P of this chapter.

5. 20 C.F.R. 416.925 provides:

(a) **Purpose of the Listing of Impairments.** The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity. Most of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

(b) **Adult and childhood diseases.** The Listing of Impairments consists of two parts:

(1) *Part A* contains medical criteria that apply to adult persons age 18 and over. The medical criteria in *Part A* may also be applied in evaluating impairments in persons under age 18 if the disease processes have a similar effect on adults and younger persons.

(2) *Part B* contains additional medical criteria that apply only to the evaluation of impairments of persons under age 18. Certain criteria in *Part A* do not give appropriate consideration to the particular effects of the disease processes in childhood; i.e., when the disease process is generally found only in children or when the disease process differs in its effect on children than on adults. Additional criteria are included in *Part B*, and the impairment categories are, to the extent possible, numbered to maintain a relationship with their counterparts in *Part A*. In evaluating disability for a person under age 18, *Part B* will be used first. If the medical criteria in *Part B* do not apply, then the medical criteria in *Part A* will be used.

(c) **How to use the Listing of Impairments.** Each section of the Listing of Impairments has a general introduction containing definitions of key concepts used in that section. Certain specific medical findings, some of which are required in establishing a diagnosis or in confirming the existence of an impairment for the purpose of this Listing, are also given in the narrative introduction. If the medical findings needed to support a diagnosis are not given in the introduction or elsewhere in the listing, the diagnosis must still be established on the basis of medically acceptable clinical and laboratory diagnostic techniques. Following the introduction in each section, the required level of severity of impairment is shown under "Category of Impairments" by one or more sets of medical findings. The medical findings consist of symptoms, signs, and laboratory findings.

(d) **Diagnoses of impairments.** We will not consider your impairment to be one listed in Appendix 1 of Subpart P of Part 404 of this chapter solely because it has the diagnosis of a listed impairment.

It must also have the findings shown in the Listing for that impairment.

(e) **Addiction to alcohol or drugs.** If you have a condition diagnosed as addiction to alcohol or drugs, this will not, by itself, be a basis for determining whether you are, or are not, disabled. As with any other medical condition, we will decide whether you are disabled based on symptoms, signs, and laboratory findings.

6. 20 C.F.R. 416.926 provides:

(a) **How medical equivalence is determined.** We will decide that your impairment(s) is medically equivalent to a listed impairment in Appendix 1 of Subpart P of Part 404 of this chapter if the medical findings are at least equal in severity and duration to the listed findings. We will compare the symptoms, signs, and laboratory findings about your impairment(s), as shown in the medical evidence we have about your claim, with the medical criteria shown with the listed impairment. If your impairment is not listed, we will consider the listed impairment most like your impairment to decide whether your impairment is medically equal. If you have more than one impairment, and none of them meets or equals a listed impairment, we will review the symptoms, signs, and laboratory findings about your impairments to determine whether the combination of your impairments is medically equal to any listed impairment.

(b) **Medical equivalence must be based on medical findings.** We will always base our decision about whether your impairment(s) is medically equal to a listed impairment on medical evidence only. Any medical findings in the evidence must be supported by medically acceptable clinical and laboratory diagnostic techniques. We will also consider the medical opinion given by one or more medical or psychological

consultants designated by the Secretary in deciding medical equivalence. (See § 416.1016.)

(c) **Who is a designated medical or psychological consultant.** A medical or psychological consultant designated by the Secretary includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. A medical consultant must be a physician. A psychological consultant used in cases where there is evidence of a mental impairment must be a qualified psychologist. (See § 416.1016 for the qualifications we consider necessary for a psychologist to be a consultant.)

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QUESTION PRESENTED

Are children seeking Supplemental Security Income disability benefits entitled to an individualized determination of all their impairments and functional limitations based upon the requirement of 42 U.S.C. § 1382c(a)(3)(A) that they be found disabled if they have "any" mental or physical impairments of "comparable severity" to those which would cause an adult to be found disabled?

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STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 1614(a)(3)(A) and (F) of the Social Security Act, 42 U.S.C. § 1382c(a)(3)(A) and (F) (1982 & Supp. IV 1986); 20 C.F.R. §§ 416.920a(c)(3), .924, .925(a), .945(a), .994(c); and SSA, Program Operations Manual System, DI 00401.335, are reproduced at Appendix, *infra*.

STATEMENT OF THE CASE

A. Statutory Framework

To complement the Social Security insurance programs, Congress in 1972 established the Supplemental Security Income ("SSI") program for indigent people who are 65 or over, blind or disabled. 42 U.S.C. § 1381, *et seq.* (1982 & Supp. IV 1986). Congress, in recognition of the extraordinary living expenses of disabled children, extended SSI in the "belief that disabled children who live in low-income households are certainly among the most disadvantaged of all Americans and that they are deserving of special assistance in order to help them become self-supporting members of our society." H.R. Rep. No. 231, 92d Cong., 1st Sess. 147-48 (1971), *reprinted in* 1972 U.S. Code, Cong. Admin. News 4989, 5133-34.

An adult is disabled under SSI if he or she "is unable to engage in any substantial gainful activity ["SGA"] by reason of any medically determinable physical or mental impairment which can be expected . . . to last for a continuous period of not less than twelve months." 42 U.S.C. § 1382c (a)(3)(A).¹ This same provision also states that a child under 18 years of age is disabled, "if he [or she] suffers from *any* medically determinable physical or mental impairment of *comparable severity*." (emphasis added).

¹ This is the same disability test that Congress had legislated earlier for disabled adults, and adults claiming to have had a disability in childhood, in the Title II Social Security Disability Insurance program. See 42 U.S.C. § 423(d)(1)(A) (general definition for "disability" for disability insurance benefits); § 402(d)(1)(C) (incorporating general definition for Child Disability insurance benefit).

Congress, by adopting the same disability test from Title II, and by invoking the "comparable severity" standard for SSI children claimants, required near identity of treatment between disabled children and adults claiming SSI benefits. Nonetheless, the Secretary established two markedly different regulatory methods and tests to measure the disabling severity of the medical impairments of adult and child claimants. This disparate treatment denies children the realistic, individualized assessment of their functional limitations which adults receive. The result is that a disability claimant under 18 is denied SSI benefits where a claimant over 18 with the identical functional limitations would be granted such benefits. The dispute here is whether Congress intended disabled children to have such dissimilar, and inferior, evaluation of their claims.

B. Regulatory Scheme—Adult Disability Evaluations

Under the SSI program, adults are evaluated using the same five-step sequential evaluation process as is used in the Title II adult and child disability insurance programs. See *Bowen v. Yuckert*, 482 U.S. 137, 140-42 (1987); 20 C.F.R. §§ 416.920, 404.1520. At step one, it is determined whether the claimant is engaging in "substantial gainful activity" ("SGA"); if so, the claim is denied. 20 C.F.R. § 416.920 (b). If the applicant is not working, the decision-maker determines, at the second step, if there is a "severe impairment" which "significantly limits . . . physical or mental ability to do basic work activities . . ." 20 C.F.R. § 416.920(c). The claim is denied if there is no "severe impairment," which screens out obviously ineligible claimants. *Yuckert*, 482 U.S. at 141.

If the impairment is "severe," the evaluation proceeds to the third step to determine whether the impairment(s) "is listed in Appendix 1 [of 20 C.F.R. pt. 404, subpt. P] or is equal to a listed impairment(s) . . ." 20 C.F.R. § 416.920(d). Such "listed" impairments are considered by the Secretary "severe enough to prevent a person from doing any gainful activity," not

merely "substantial gainful activity." 20 C.F.R. § 416.925(a) (emphasis added).²

This third step was intended to "streamline" the decision-making process by identifying claimants with the most severe medical impairments, *Yuckert*, 482 U.S. at 153, granting benefits "without further inquiry" into the complete impact of the claimant's disabling impairments, *Heckler v. Campbell*, 461 U.S. 458, 460-61 (1983). The listings embody very high levels of severity so that a qualifying claimant may be "conclusively presumed to be disabled and entitled to benefits." *Bowen v. City of New York*, 476 U.S. 467, 471 (1986). Further, the Secretary has repeatedly stated that the listings, whether adult or childhood, do not attempt to include all impairments that may be disabling, but rather include only the more "commonly" or "frequently" diagnosed conditions.³

Claimants who do not satisfy the precise requirements of a listed impairment also can be found disabled at step three if their impairments are considered "medically equal" to a listed impairment. 20 C.F.R. §§ 416.920(d), 416.926. What constitutes "medically equal" has been the subject of conflicting positions by the Secretary. Since at least 1980 the Secretary has prohibited consideration of the functional consequences of

² The listings severity level is thus set at a threshold considerably higher than that of the statute. See 42 U.S.C. § 1382c(a)(3)(A) ("unable to engage in any substantial gainful activity").

³ See, e.g., 50 Fed. Reg. 50068, 50069 (1985) (list contains only most "frequently diagnosed" impairments); 44 Fed. Reg. 18170, 18175 (1979) ("The Listings criteria are intended to identify the more commonly occurring impairments . . ."). The Secretary acknowledges that experience may reveal that he "overlooks certain impairments" (Pet. Br. 42). Such "oversights" miss entire categories of childhood impairments, such as Down and Tourette Syndrome. No usable list can ever encompass all potentially disabling impairments. Thus, while we welcome the Secretary's recent proposal to update the childhood listings for mental impairments, 54 Fed. Reg. 33238 (1989), they too can never hope to encompass every disabling condition.

impairments at step three under the "equals" concept. Instead, he confines his inquiry to matching precise clinical findings with those in his listings. Social Security Ruling ("SSR") 83-19. (J.A. 236).⁴ The Ruling provides that "it is incorrect to consider wh[et]her the listing is equaled on the basis of an assessment of *overall* functional impairment The functional consequences of the impairments (i.e., RFC) [Residual Functional Capacity], irrespective of their nature or extent, *cannot* justify a determination of equivalence." (J.A. 239-40) (emphasis in original).⁵

At the final two steps of the five-step process, the Secretary "must assess each claimant's *individual* abilities." *Campbell*, 461 U.S. at 467 (emphasis added). He determines whether the claimant can pursue former work (step four) or any other work in the national economy (step five), given his or her "residual functional capacity" ("RFC"). RFC is, in turn, based upon all medical and functional factors. The RFC evaluation of "individual abilities" is made by a reviewing physician. *City of New York*, 476 U.S. at 471 n.1. It is *separate* from the purely vocational assessment, based on the statutory factors of "age, education and work experience," 42 U.S.C. § 1382c(a)(3)(B), used to determine whether jobs exist which the claimant could perform. 20 C.F.R. §§ 416.920(e) & (f), 416.960-969. See *Campbell*, 461 U.S. at 467.

RFC is a "*medical* assessment" of what the claimant "can still do despite [his or her] limitations," 20 C.F.R. § 416.945(a) (emphasis added), and broadly encompasses basic physical abilities (*e.g.*, "walking, standing, lifting, carrying, pushing . . ."), § 416.945(b), and mental functioning (*e.g.*, "ability to understand, to carry out and remember instructions . . ."),

⁴ Social Security Rulings are statements of policy that lack the force and effect of law but are binding on all Social Security adjudicators. 20 C.F.R. § 422.408; see *Heckler v. Edwards*, 465 U.S. 870, 873 n.3 (1984).

⁵ The failure of the Joint Appendix to emphasize the word "overall" is a typographical error.

§ 416.945(c).⁶ See also SSA, Program Operations Manual System ("POMS"), DI 24510.001 (Residual Functional Capacity). (J.A. 244).⁷ According to the POMS, RFC includes not only formal medical evaluation but "descriptions and observations of the claimant's restrictions by both medical and non-medical sources." (J.A. 245). When multiple physical and/or mental impairments are present, "the RFC is derived from an assessment of the remaining functional capacity after consideration of all impairments." *Id.*

The inquiry at steps four and five is also the point at which the Secretary considers pain, nausea, dizziness, side effects of medication, and other symptoms which "may include descriptions (even your own) of limitations that go beyond the symptoms that are important in the diagnosis and treatment of your medical condition." 20 C.F.R. § 416.945(a); see also 42 U.S.C. § 1382c(a)(3)(G)(Supp. IV 1986). The Secretary recognizes that where "the listed impairment criteria are not met or equaled, but one or more of the impairments are severe, . . . [i]n assessing symptoms such as pain, as a factor of RFC, *the functionally limiting effects of the symptom* can play a significant role." SSA, POMS DI 24510.030 (J.A. 256) (emphasis added).⁸

⁶ The Secretary's brief obfuscates the nature of the RFC assessment, by characterizing it as an assessment of "non-medical" factors. (Pet. Br. 16, 18, 26, 38). He draws an artificial distinction between evaluation of a child's "medical factors and evidence alone," and "individualized consideration of vocational or similar non-medical factors (or, therefore of the *claimant's RFC*)" (Pet. Br. 26) (emphasis added), erroneously suggesting that RFC is not a medical determination.

⁷ The Program Operations Manual System is a set of guidelines, *Drombetta v. Sec'y of HHS*, 845 F.2d 607, 609 (6th Cir. 1987), for the state agencies that adjudicate all SSI claims. 42 U.S.C. § 421(a) (1982) & Supp. IV 1986).

⁸ The breadth and focus on the individual in the RFC analysis here is critical because, despite the obvious relevance of an impairment's symptoms, such as pain, unless the exact clinical signs and laboratory

Because of the breadth of the RFC assessment, for whole classes of impairments, such as mental disorders, the RFC evaluation is the *primary* method for assessing disability. See SSR 85-16.⁹

Thus it is apparent that, for adults, the individualized RFC assessment, by realistically accounting for "each claimant's individual abilities," *Campbell*, 461 U.S. at 467, allows for an appropriately flexible approach for situations that defy "formal codification" (J.A. 97) or "cookbook adjudication." It allows for decisions to be made for claimants with multiple, combined impairments; claimants with unlisted impairments; and claimants with impairments whose symptomatology, while severe, does not match all of the elements or required proofs of a

findings are present, "the symptom cannot be persuasive [at the third step] that the Listing is met or equalled." SSA, POMS DI 24505.015(D) (J.A. 255):

No alleged or reported intensity of the symptoms can be substituted to elevate impairment severity to equivalency . . . "[S]evere," "extreme," or "constant" pain will not compensate for the missing medical findings and permit an 'equals' determination.

Id. (emphasis in original).

⁹ SSR 85-16, which excludes "children under 18," emphasizes the "importance" and flexibility offered by an RFC assessment of an adult's mental disorder (West's Soc. Sec. Rptng. Serv. 424-28 (Rulings Supp. 1989). See also 20 C.F.R. § 416.920a(c)(3) (RFC evaluation of mental impairments "unless you are claiming benefits as a disabled child"). Other regulatory statements show how the RFC inquiry provides an individualized assessment, especially for mental disorders. See, e.g., 50 Fed. Reg. 35038, 35046 (1985) (all limitations including the side effects of medication must be considered in assessing RFC); *id.* at 35051 ("Individuals with personality disorders which . . . do not meet or equal the listings would still have a detailed RFC completed which would lead to a finding of disability in appropriate cases."); *id.* at 35050 ("[D]isability for individuals with IQ's in the range of 70-79 is more appropriately determined when the individual's RFC and vocational factors are considered.").

particular listing. It also allows proper recognition of pain, side effects of medication, or other limitations. As the Secretary himself has concluded, "the determination of RFC is crucial if the person does not meet or equal the Listings." 50 Fed. Reg. 35038, 35042 (1985).

C. Regulatory Scheme—Childhood Disability Evaluations

Instead of the five-step sequential evaluation process, disabled child claimants receive only a three step evaluation. The RFC evaluation is never done for children, although it is for adults. (J.A. 74, 86-87). Children can be found eligible only if they meet or equal the listings of impairments. 20 C.F.R. §§ 416.924, 416.925. The child listings use the same medical assumptions and level of severity as the adult listings. 42 Fed. Reg. 14706 (1977).

The Secretary recognized in his initial promulgation of the child listings that there would be "children who have an impairment that is not included in the [listing] Appendix," 42 Fed. Reg. at 14706 (1977), and that the listings embody only the most "frequently diagnosed" impairments. *Id.*; see note 3, *supra*, and note 19, *infra*. Neither the 120-odd adult listings or the 57 children's listings can cover the hundreds of discrete disorders or the almost infinite combinations of impairments afflicting children.

This listings-only approach, coupled with the exclusion of functional assessment, was a significant departure from the early regulatory history of the SSI child disability program, as embodied in two Disability Insurance Letters issued by SSA (J.A. 89, 94). See pp. 27-33, *infra*. The Secretary's current position constitutes a more restrictive policy concerning "comparable severity," equivalence and the relevance of functional limitations than was adopted at the outset of the SSI program. See *id.*

D. Named Plaintiffs And Class Members

Brian Zebley initiated this action on July 12, 1983 and was joined by two intervenors, Joseph Love, Jr. and Evelyn Raushi.

Together they represent a certified class of denied child applicants and terminated child beneficiaries. (J.A. 27). The briefs of the amicus parties—a majority of states and over two dozen professional medical, disability, and children's organizations—further establish that severely disabled children, including those with impairments such as spina bifida, cystic fibrosis, Down Syndrome, and muscular dystrophy, have been routinely rejected for SSI under the listings criteria and denied individualized assessments of functional limitation.

Brian Zebley

Like many children brain damaged at birth, Brian has always suffered from multiple impairments: congenital brain damage with spastic right hemiparesis, mental retardation, developmental delay, eye problems and musculoskeletal impairments. *Zebley*, 855 F.2d at 70-71. Although Brian was initially awarded SSI at age two upon a finding that he met the mental retardation listing, he was terminated less than two years later on the grounds that he “no longer met or equaled the requirements of any section of the Listings of Impairments at Appendix 1.” *Id.* at 71. (See J.A. 41-45).

The Secretary concluded that “Brian Zebley has significant limitations compared with other children of his age,” including, at four years of age, the gross motor skills of a 16-19 month old, spasticity and uncoordination; misjudging of distances and frequent falling; and self-help and perceptual/fine motor skills at or below 50% of those of a normal child. (J.A. 43-44). Despite these developmental impairments which, “adjusting for age, [left] Brian . . . no better off now [at age four] than he was when benefits were initially awarded in 1980” (J.A. 29), the Secretary determined that Brian no longer met the childhood mental retardation listing and terminated his benefits.¹⁰

¹⁰ The childhood mental retardation listing requires a delay in *all* developmental skills of “more than one half of the child’s chronological age.” 20 C.F.R. Pt. 404, Subpt. P., App. 1, § 112.05(A). (J.A. 233). At 48 months of age, although Brian showed delay in gross motor and self-help skills of more than one-half his age, his non-motor skills, like cognition and language, were in the 36-42 month range. (J.A. 31, 43).

The “degree of severity” of impairment of Brian’s motor coordination, that of a one to one-and-a-half year old when he was four years of age, is deemed irrelevant under the Secretary’s listings-only policy. (J.A. 255). An “assessment of overall functional impairment” is also explicitly prohibited by the Secretary in multiple impairment cases. SSR 83-19 (J.A. 239); SSA, POMS DI 24505.015(C) (J.A. 251). The district court found that the Secretary’s decision was not supported by substantial evidence of improvement, but noted that he could revisit the case again. (J.A. 34).

Joseph Love, Jr.

Joseph Love, Jr. was ten years old in 1983 when he was denied SSI benefits despite organic brain syndrome manifested by a psychiatric impairment (a severe adjustment disorder with mixed emotional and behavioral disturbances), a neurological impairment (severe hyperkinesia), and involuntary movements with visual/motor misperception. (J.A. 52-53, 56).¹¹ Joseph not only failed first grade three times but also could not adapt to special education classes, necessitating home-bound instruction. (J.A. 50). At the time of the ALJ hearing, he was functioning on a kindergarten level although he had been in school for four years. These educational failures had caused him “severe emotional stress.” (J.A. 54).

Because Joseph could undertake some “self-care” activities (“he help[ed] with the dishes occasionally”) (J.A. 51), he did not meet *all* four of the listed criteria for childhood psychosis or non-psychotic disorders, §§ 112.03, 112.04 (J.A. 232-33). He also did not have a complete arrest in development (as opposed to impaired development) as required by the chronic brain

¹¹ Joseph also was diagnosed as suffering from an attention deficit disorder and described “as being very impulsive, apprehensive and a poor learner. He was unable to relate with his peers, control his aggressions easily or learn.” (J.A. 53). He went to sleep at 2:00 a.m., woke at 6:00 a.m., was unable to sit still, and was constantly climbing on top of things, sliding across the floor, running up and down steps, getting upset easily, and becoming depressed. (J.A. 50-51).

syndrome listing. § 112.02 (J.A. 232). On further appeal, the district court remanded the case to the Secretary for a new determination. (J.A. 37).¹²

A psychiatric consultant in the Secretary's national Office of Disability admitted that Joseph's precise symptoms appear "fairly often" in both children and adults. (J.A. 85-86). While he acknowledged that an *adult* with such symptoms could be found disabled by an individualized RFC assessment, a *child* with the "identical functional symptomatology" would never be found disabled. (J.A. 86-87).

Evelyn Raushi

Evelyn Raushi was born prematurely in 1974, and was determined disabled in 1979 based upon a 62 IQ. (J.A. 61). Her benefits were subsequently terminated as of October, 1981. *Id.* Further tests showed Evelyn had a developmental delay of two years manifested by "emotional immaturity and intellectual and social impoverishment consistent with [her] development delay"; "significant latent anxiety"; and, in addition to mental retardation, diagnoses of "developmental learning disorder" and "minimal brain dysfunction." (J.A. 63). Although the Secretary determined that Evelyn was retarded, he found that she did not suffer from another significant impairment, as required by listing § 112.05(C). (J.A. 64, 233).

Evelyn's case, however, was remanded to the Secretary for a new determination as to whether she showed "medical improvement" (J.A. 36) pursuant to Section 2 of the Social Security Disability Benefits Reform Act of 1984, 42 U.S.C. § 423(f) (Supp. IV 1986), and she was thereafter reinstated.

E. Court Of Appeals Decision

A unanimous Third Circuit panel found the Secretary's approach to be "inconsistent with the statute in precluding a

¹² Joseph was subsequently found disabled, but only for the period after Nov. 15, 1985. That decision is still in litigation.

finding that a child is disabled unless his impairment meets or equals a listed one." 855 F.2d at 73-74. The court determined that "Congress has expressed unambiguously its intent that 'any' impairment which meets the statutory standard shall be found disabling. Therefore, the Secretary's regulatory method for determining disability must be adequate to identify any qualifying impairment." *Id.* at 73. The court reasoned that the listings, designed to identify only the most severely disabled claimants for quick, presumptive awards, "do not purport to be an exhaustive compilation of medical conditions which could impair functioning to the extent necessary to satisfy the statutory standard for disability," yet only adults are given the further opportunity to establish eligibility through an "individualized assessment of the *actual* degree of functional impairments" *Id.* (emphasis in original). Because it was the expressed intention of Congress to allow children to show that they suffered from "any" impairment of "comparable severity" to one "which would actually, even if not presumptively, disable an adult," the Secretary's regulatory method identifying "only *some* comparable impairments" was held to be inadequate. *Id.* at 73-74 (emphasis in original).

The court specifically rejected the reasoning in *Hinckley v. Sec'y of HHS*, 742 F.2d 19 (1st Cir. 1984), and *Powell v. Schweiker*, 688 F.2d 1357 (11th Cir. 1982). *Powell* mistakenly characterized child claimants as arguing that comparability required the Secretary to make up childhood analogues for the adult vocational factors of age, education and work experience. The real question at issue, however, is whether children are entitled to an individualized functional assessment of the impact of their impairments, notwithstanding the inapplicability of vocational factors. 855 F.2d at 74. The Third Circuit also criticized *Hinckley's* mistaken reliance upon equivalence as affording functional assessment, noting that the Secretary has stated that the functional consequences of impairments cannot justify a determination of equivalence. SSR 83-19. Since the Third Circuit decision, the Secretary's equivalence regulation has been struck down in *Marcus v.*

Bowen, 696 F. Supp. 364 (N.D. Ill. 1988), *appeal pending*, No. 89-2717 (7th Cir.), which contains a thorough discussion of the regulatory history of the Secretary's listings-only policy and particularly the shortcomings of his equivalence policy.¹³

Rather than "jettison[ing] the entire regulatory framework," as the Secretary characterizes the decision (Pet. Br. 42), the Court of Appeals retained the regulatory scheme, remedying only the absence of an assessment of the impact of functional limitations. In holding that the Secretary must evaluate the impact of the child's impairment and make individual assessments of the possible disabling effects, the court did not encroach upon the Secretary's prerogative to devise a standard against which to assess a child's residual function capacity. As Judge Mansmann wrote, "We see no necessity for such an intrusion upon the Secretary's authority." 855 F.2d at 75. The Court of Appeals left the Secretary considerable latitude to augment his approach to children's disability to make it truly comparable to that afforded adults.

SUMMARY OF ARGUMENT

Realistic assessment of functional limitations is the guiding principle in all disability determinations. The Secretary's inferior program for evaluating children's SSI claims is contrary to the plain meaning of the SSI statute which commands that a child be found disabled if he or she suffers from any impairment of comparable severity to that which would render an adult disabled. Since adults are individually assessed to determine their actual residual functional capacity, if they do not meet one of the specific listings set at high levels of presumptive disability, it violates this "comparable severity" stan-

¹³ The Eighth Circuit has ruled in favor of the Secretary, albeit on the limited ground that the particular listing in question apparently allowed inquiry into function so as to obviate the need to hold the Secretary's overall approach to be unlawful. *Nash v. Bowen*, No. 88-2542 (August 10, 1989).

dard to stop the inquiry for children once it is determined that they do not meet one of these listings. The Secretary has recognized that the listings are designed to screen for common impairments that can be presumed disabling, and has repeatedly acknowledged their inherent inadequacy for individually assessing actual functional loss.

The Secretary has explicitly recognized that, by limiting children to a listings-only test, he is using the "any gainful activity" test of the widow's disability program, instead of the "substantial gainful activity" test of the adult disability program. Because Congress chose to make children subject to the more liberal test of the adult program, however, the exclusive use of the listings for children imposes a level of severity that exceeds the statutory standard.

The Secretary's current interpretation is not due any special deference because it was not developed contemporaneously and is inconsistent with his earlier interpretations. Further, because the Secretary's current interpretation was never made known to Congress, it did not give, and could not have given, its approval to that interpretation through its passage of related legislation or otherwise. Indeed, the legislative history of the related legislation relied upon by the Secretary shows that Congress was dissatisfied with his inaction in implementing the SSI children's program, and suggests that Congress endorsed a more flexible approach that went beyond the listings.

The Secretary's argument that there are no feasible benchmarks for individually assessing children's functional limitations is belied by his own policies and regulations, which specifically endorse assessment of "age-appropriate activities" as such a workable standard, as well as by the accepted diagnostic and treatment practices of the medical community. Indeed, both in assessing medical improvement in disabled children and in determining entitlement to Title II disability benefits for disabled adults who became disabled when they were children, the Secretary already explicitly analogizes abil-

ity to work with ability to perform age-appropriate activities and other "work-like" activities performed by children.

ARGUMENT

I. THE SECRETARY VIOLATES THE "COMPARABLE SEVERITY" STANDARD OF THE ACT BY DENYING DISABLED CHILDREN INDIVIDUALIZED ASSESSMENTS OF THEIR FUNCTIONAL LIMITATIONS.

The holdings of this Court in *Campbell*, *Yuckert* and *City of New York* make it clear that assessment of functional limitations is to be the guiding theme governing all disability adjudications. While the Secretary may take steps to ease his workload by developing methods to deal with certain repetitive employment questions not unique to the individual, *Campbell*, or to weed out cases where the claimant has only a slight impairment, *Yuckert*, he has never been permitted to give less than a full assessment of the difficult question of whether disability exists. Never has it been suggested that convenience may outweigh individualized decision-making. Although "impairments" may be medically catalogued, "disabilities" can only be adjudged by examining how a medical condition actually affects an individual.

While asserting that the listings take into account the impairment's "impact on development" (Pet. Br. 38), the Secretary nevertheless admits that "regulations focus . . . not on the individual child's ability to function as such" (*id.* 42). He also admits that, in his asserted consideration of "impact," he gives "no individualized consideration" to RFC or functional limitations but instead makes a "legislative-type assessment" of impact. (*Id.* 38). Insofar as impact is considered, then, it is on the basis of predicting average functional loss from diagnostic findings.

The reality for disabled children is that the Secretary's policies have established a listings-only methodology for evaluating childhood disabilities that, on its face, precludes any fair and realistic assessment of the functional impact of childhood

impairments on the individual child. As such, this methodology may not be used to disqualify those who meet the statutory definition of disability. See *Yuckert*, 482 U.S. at 158 (O'Connor, J., concurring).

A. The Statute Plainly Envisions An Individualized, Functional Test For Children.

The search for the proper method of evaluating the impairments of children begins with the meaning of § 1614(a)(3)(A) of the Social Security Act. The same statutory authorization that gives the Secretary rulemaking authority circumscribes this authority to prescribing procedures "not inconsistent with the provisions of this title." 42 U.S.C. § 405(a), made applicable to the SSI program by 42 U.S.C. § 1383(d)(1) (1982 and Supp. IV 1986), see *Campbell*, 461 U.S. at 466. At issue here is a "pure question of statutory construction for the courts to decide." *I.N.S. v. Cardoza-Fonseca*, 480 U.S. 421, 446 (1987). The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear Congressional intent. 480 U.S. at 447-48. In discerning the plain meaning of this statute, the court must look to the "express language" of the statute at issue as well as to the "language and design of the statute as a whole." *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, —, 108 S.Ct. 1255, 1258 (1988) (Kennedy, J.) (rejecting "strained interpretation [of the Social Security Act] offered by the Secretary").

"The Social Security Act defines 'disability' in terms of the effect a physical or mental impairment has on a person's ability to function" *Campbell*, 461 U.S. at 459-60. Functional loss is the talisman of our disability law. By looking to the ability to perform substantial gainful activity, given the person's "medically determinable physical or mental impairment," 42 U.S.C. § 1382c(a)(3)(A), the law takes a "functional approach to determining the effects of medical impairments." *Yuckert*, 482 U.S. at 146, 482 U.S. at 166 (Blackmun, J., dissenting). Instead of an approach based upon a finite number of diagnostic categories, and the average functional loss

thereby created, the disability program is meant to provide a "realistic, individual assessment of each claimant's ability to engage in substantial gainful activity." *City of New York*, 476 U.S. at 474.¹⁴

The evaluation of the actual performance abilities of adult disability claimants (the RFC assessment) is undertaken at the fourth and fifth steps of the sequential evaluation process, after it has been determined inappropriate to award benefits based solely on the listings. *Id.* at 471. This focus upon functional capacity was recently reinforced by § 4 of the Social Security Disability Benefits Reform Act of 1984, which requires that "the combined effect of the impairments shall be considered throughout the disability determination process." 42 U.S.C. § 1382c(a)(3)(G) (Supp. IV 1986) (emphasis added).

In *Campbell*, this Court interpreted the statute as "specifying consideration of each individual's condition," with the statutory scheme as a whole anticipating "individualized determinations" for each claimant. 461 U.S. at 458. As *Campbell* makes clear, the point at which the Secretary "must assess each claimant's individual abilities [*i.e.*, RFC]" comes after the listings evaluation. *Id.* at 467. There is simply no authority for the position of the Secretary that an inquiry as to whether a person meets or equals a listed impairment satisfies the statute's call for individualized assessment. (Pet. Br. 41-42). To the contrary, the outcome of *City of New York*, 476 U.S. at 474-75 n.5, refutes the Secretary's attempt to cast the listings stage as

¹⁴ In contrast, Congress adopted the "average man" standard for veterans' disability benefits. 38 U.S.C. § 502 (a)(1) (impairment "sufficient to render it impossible for the average person to follow a substantially gainful occupation"). The "average man" standard has never been applied under the Social Security Act, as courts have uniformly held that each claim requires individualized adjudication. See, e.g., *Franklin v. Sec'y of Health, Education and Welfare*, 393 F.2d 640, 642 (2d Cir. 1968); *Dillon v. Celebrezze*, 345 F.2d 753, 757 (4th Cir. 1965). The Secretary has fully subscribed to the principle of individualized adjudication. E.g., 43 Fed. Reg. 9291 (1978).

his vehicle for rendering individualized assessments of functional limitations.

When Congress recognized the extraordinary needs of poor, disabled children by including them in the new SSI disability law, it provided for the same individualized, functional assessments to apply to children as were applied to adults. No separate program or alternative methods were legislated for disabled children. Rather, the same approach was provided by the express linking of children to the definition of disability for adults in the new SSI law, 42 U.S.C. § 1382c(a)(3)(A), a definition also employed in the pre-existing Title II program for disabled adult workers, and for adult children of deceased, disabled or retired workers, claiming a childhood onset of disability. 42 U.S.C. §§ 423(d)(1)(A), 402(d)(1)(C) (1982).¹⁵ See *Yuckert*, 482 U.S. at 140.

When Congress enacted a "comparable severity" standard for children in § 1382c(a)(3)(A), the use of the term "severity" referred to the elaboration of the disability definition found in subsection (B), namely, impairments of such "severity" that they preclude "previous work" and "any other kind of substantial gainful activity." 42 U.S.C. § 1382c(a)(3)(B). That is the "severity" to which Congress intended children's impairments to be comparable. Therefore, the Secretary's suggestion (Pet. Br. 29) that subsection (B) does not apply to children, and purposely excludes them, is contrary to the plain meaning of the statute.

Congress, by utilizing a term ("comparable") that it had employed in similar benefit programs to establish near-identical treatment, insured both equity and uniformity of process

¹⁵ Congress stated that the "definition of disability . . . used in the disability insurance program established under Title II of the Social Security Act would be generally applicable to disabled . . . people under age 65" in the SSI program. H.R. Rep. No. 231, 92d Sess., 1st Sess., reprinted in 1972 U.S. Code, Cong. Admin. News 4989, 5233.

for children. The term "comparable" has been discussed by this Court on at least three occasions.

Title XIX of the Social Security Act (Medicaid) has required that the medically needy be treated in a manner "comparable" to the categorically needy. 42 U.S.C. § 1396a(a)(10) (amended 1981), and (a)(17). See *Atkins v. Rivera*, 477 U.S. 154 (1986); *Schweiker v. Hogan*, 457 U.S. 569 (1982). In both cases, the Court recognized that Congress' requirement of comparability mandated near identity of treatment. While two groups may be situated in such a way that exactly congruent treatment may be impossible, comparable treatment requires that the treatment afforded be as close to identical as possible. Thus, the Court in *Schweiker v. Hogan* speaks of the comparability clause of 42 U.S.C. § 1396a(a)(17) as requiring identical treatment for the aged, blind, disabled and dependent. 457 U.S. at 573 n.6. The Court cited with approval four court of appeals decisions, all of which interpreted "comparable" to require that the identical rule of eligibility be applied to the categorically needy. *Id.* at 587 n.28.

This notion of near-identical treatment already was a concept that Congress found useful in mandating equal treatment for groups that, by their very nature, have certain features that defy exactly the same treatment. Thus, when Congress instructed the Secretary in 1972 to evaluate the severity of the impairments of children in a manner comparable to adults, it is reasonable to assume that it had in mind the same kind of near-identical treatment that it had established seven years earlier in a different title of the same Act.

Similarly, in *Wheeler v. Barrera*, 417 U.S. 402 (1974), the Court construed a regulation requiring "comparable treatment" for special education children in public and private schools. Justice Blackmun there observed that, at the very least, "comparability" could not countenance a clearly "inferior program." *Id.* at 422 n.17. He added that, to achieve "comparability" among the two classes of beneficiary children, a

program would have "to equalize the level and quality of services offered." *Id.* at 425.¹⁶

Finally, by adding for children the modifier "any" before "medically determinable physical or mental impairment of comparable severity," Congress has expressed unambiguously its intent that "any" impairment which meets the statutory standard shall be found disabling. The Secretary's method of identifying only some comparable impairments does not satisfy the statute. Given the expressed congressional intention that children be afforded the opportunity to demonstrate they suffer from "any" impairment of "comparable severity" to one which would *actually*, even if not presumptively, disable an adult, the regulatory method for children must include the method offered to adults, *i.e.*, an opportunity for assessing actual degree of functional impairment.

B. The Childhood Listings-Only Method Does Not Embody The Functional Approach To Disability Evaluation Required By The Statute.

As the sole means of evaluating disability, the listings have several shortcomings.¹⁷ First, any set of listings is never going to be complete given the complexities of the human organism, the ever changing nature of modern society and the impracticality of listing rare disorders. For example, AIDS and newborn drug addiction were virtually unknown 15 years ago; now

¹⁶ The Secretary would define "comparable" to mean "permitting or inviting comparison[,] often in one or two salient points only." (Pet. Br. 24). But individualized assessment is *the* salient feature of the program. Respondents do not assert that absolutely identical treatment must be afforded. However, given the "crucial" and determinative role that the Secretary has acknowledged the RFC has in adult adjudications, its exclusion for children belies the rhetoric that "essentially identical" evaluation methods are used.

¹⁷ This is not to say that we reject their utility as a streamlining device; rather, we object to their use as the sole determinant of disability.

they are all too common. Second, modern science is constantly refining its diagnostic tools and procedures so that the medical indicia in the listings are frequently outdated. Third, even if a particular impairment is listed and the criteria are up to date, it is impossible to predict how different people will react to the same impairment. Subjective manifestations such as pain, dizziness and reactions to medication are impossible to predict with precision. Fourth, the listings cannot take the combined effect of multiple impairments into account without an individualized assessment of functional limitations. Finally, some claimants will be too young or too infirm to test, although there may be other ways to evaluate their impairments without resort to a particular listed procedure.

A graphic example of the limitations of the listings in evaluating rare childhood afflictions is seen in *Wilkinson v. Bowen*, 847 F.2d 660 (11th Cir. 1987) (*per curiam*), following *Powell v. Schweiker*, 668 F.2d 1357 (11th Cir. 1982). A ten month old infant, Derik Wilkinson, sought SSI on the basis of a rare chronic liver disease, Alpha I Antitrypsin deficiency, as well as significant developmental delay. 847 F.2d at 662. As described by the court, young Derik is

essentially confined to his home, except for trips to the doctor. He swells, cannot eat, and runs a fever three or four nights a week. The swelling of his arms, legs, and feet causes pain. He has been hospitalized four times, and he tires easily. The doctors say he has a life-long condition, precluding a normal childhood and adult life. He has allergic reactions to any kind of food. He requires constant attention, and when he swells up, he must be held all night.

847 F.2d at 661-62. Despite the extraordinarily deleterious impacts of this condition, the Eleventh Circuit affirmed the Secretary's denial of SSI because Derik did not meet or equal the mental retardation listing, § 112.05(A), the closest listing the Secretary could identify. The Secretary's description of his approach in *Wilkinson* and similar cases "as a reasonable implementation of the statutory standard" (Pet. Br. 17-18) is contrary to the remedial purpose of the Act.

The Secretary has himself repeatedly acknowledged the serious limitations of the listings-only approach, as well as the need to go beyond the listings to provide realistic functional assessments. The regulatory history of the listings establishes their intrinsic limitations with regard to individual assessment of functional restrictions.

As originally published, the listings were thought to be "medical guides" intended to "facilitate identification of clear-cut cases," leaving "[c]onditions that fall short of the severity of those described in the guides [to be] evaluated in terms of whether in fact they prevent the applicant from engaging in any substantial gainful activity." *Administration of Social Security Disability Insurance Program, 1959: Hearings Before the Subcommittee on the Administration of the Social Security Laws of the House Comm. on Ways and Means, 86th Cong., 1st Sess. 334 (1959)* (hereinafter, "1959 Disability Insurance Hearings").

In 1959, Dr. William Roemmich of SSA stated:

I would like to emphasize that the guides are not now, and were at no time in the operation, intended to separate all applicants into allowances and denials. . . .

[The] specific medical listings and guides in our operating manual . . . are administrative tools, rather than rules. They contain, in broad terms, clinical descriptions of the more common disabling conditions. They do not show all possible disabling conditions nor do they indicate the combining effect of different impairments.

Id. at 342.¹⁸ The drafters of the listings never intended them to establish "cookbook adjudication" for claimants. *Id.* at 85. *Marcus*, 696 F. Supp. at 375.

¹⁸ Associate Director Arthur E. Hess also testified that the listings were set at a higher level of severity than ultimately called for by the Act, in order to make presumptive allowances. Failure to meet the listings was not to lead to disallowance. *Id.* at 350.

From the point when the medical guides were published as the listings, 33 Fed. Reg. 11741 (1968), to the present, the limited screening role they were intended to have and their high level of severity has not changed. *See Marcus*, 696 F.Supp. at 375 & n.11. Indeed, the Secretary has repeatedly declared his own belief that the listings are not mechanisms to decide whether a person is disabled, and has assumed that only when one goes beyond the listings to an RFC assessment will a realistic determination of disability be obtained. *Id.* at 375-76 (citing such repeated regulatory statements).¹⁹ The Secretary thus has adopted respondents' position by declaring that "the determination of RFC is crucial if the person does not meet or equal the Listings." 50 Fed. Reg. at 35042 (1985).

When the Secretary belatedly promulgated his Part B child listings, he placed them in the conceptual framework of the adult listings established almost two decades earlier. Just as Congress was assured in 1959 that the adult listings for disability insurance described only "the more common disabling conditions" and did "not show all possible disabling conditions nor . . . the combining effect of different impairments," 1959 *Disability Insurance Hearings* 342, the Secretary in 1977 acknowledged the limitations of the new childhood listings, by

¹⁹ *See, e.g.*, 44 Fed. Reg. 18178 (1979) (listings but "one element" in the determination process); 45 Fed. Reg. 55576 (1980) (response to comments that medical equivalence standards were too restrictive). In response to a criticism in 1979 of the narrow multiple sclerosis listing for failing to consider overall impact, the Secretary acknowledged:

[M]ultiple sclerosis, a disease with variable and multiple manifestations, can be shown to be a severe impairment by a combination of symptoms and signs other than those described by the listed criteria. It is not possible, however, to reduce these multiple manifestations to a listing. The Listing is but one item in the evaluation process. We evaluate cases of claimants whose conditions do not meet or medically equal the criteria of a listed impairment under other rules. . . .

44 Fed. Reg. 18176.

admitting that they only "evaluate the more common impairments" and acknowledging the existence of "children who have an impairment that is not included in the Appendix." 42 Fed. Reg. at 14706.²⁰

The limited, "screening" role of the listings and their facial inadequacy in addressing all possible impairments would not be objectionable if, like adults, children received the RFC assessment of "each claimant's individual abilities," *Campbell*, 461 U.S. at 467, or even if the listings stage could somehow fully take into account all the functional limitations of "any" impairment "which would actually, even if not presumptively, disable an adult." *Zebley*, 855 F.2d at 73. The Secretary's policies, however, foreclose both. He precludes an RFC assessment on the mistaken assumption that this can only be relevant and workable for those in the labor market, *see* Section III, *infra*. He admits that his listings "focus . . . not on the individual child's ability to function as such . . .," and for the most part offer "no individualized consideration" of functional limitations. (Pet. Br. 38, 42). *See also* 42 Fed. Reg. 14706 (listings interpret "severity [of disability] in medical rather than functional terms").²¹ The Secretary can make no claim greater than

²⁰ Not only do children with "uncommon" impairments find their way to benefits blocked, *Report of the National Commission on Orphan Diseases*, xiii (DHHS 1989) (surveying 5,000 rare diseases), but, indeed, even those with relatively common childhood impairments such as Down Syndrome, Tourette Syndrome, and autism do not have their impairments listed. H. Fox & A. Gearney, *Disabled Children's Access to SSI and Medicaid Benefits* 55 (1988) (hereinafter, "*Fox Report*") ("More often than not . . . the disability criteria exclude young children or simply ignore them."). The Fox Report and the National Commission Report, both funded by the Secretary, have been lodged with the Clerk of the Court.

²¹ A more detailed picture of the Secretary's shortcomings in evaluating functional limitations is provided in the *Fox Report* 58-59 ("The disability criteria do not consider a child's functional limitations, such as limitations in the ability to perform age-appropriate daily activities like school and play The listing . . . does not address the functional limitations caused by an impairment in any uniform and consistent manner. . . .").

that "some of the criteria in Part B" assess functional capacity where "relevant." (Pet. Br. 42) (emphasis added).²²

At least initially there was a possibility that, under a broad reading of the "equals" to the Listings concept, functional limitations could be assessed. See 1974 DIL (J.A. 97). However, even this avenue was later foreclosed by SSR 83-19. Contrary to the assertion of flexibility (Pet. Br. 40), since that Ruling was adopted it has been "incorrect to consider whether the listing is equaled on the basis of an assessment of *overall* functional impairment The functional consequences of the impairments (i.e. RFC), irrespective of their nature or extent, *cannot* justify a determination of equivalence." SSR 83-19 (J.A. 239-40) (emphasis in original).²³

²² The Secretary thus implies that all other functional incapacity is irrelevant in assessing "severity." This position is unfounded since the RFC assessment is applied to *all* adults who do not satisfy the listings. The Secretary's contention that he considers functional incapacity in the childhood listings wherever relevant also ignores the near-total absence of any reference to pain (which frequently results in functional limitations) in the listed criteria, despite the command of Section 3(a)(1) of the Social Security Disability Benefits Reform Act of 1984, 42 U.S.C. § 1382c(a)(3)(G) (Supp. IV 1986), to consider pain.

²³ When this restrictive equivalence policy is joined to a listings system which includes only discrete disorders, the result for children is:

[t]he failure of the disability determination system to take into account the severely disabling impact of multiple impairments [E]ven some fairly common multiple impairments, such as ventilator-dependency and developmental delays, had not been addressed adequately. The significance of this problem was underscored by unpublished data from . . . the American Academy of Pediatrics Committee on Children with Disabilities [showing] that increasing numbers of children are surfacing with complex medical conditions that may involve as many as five or more different diagnoses.

Fox Report 54, 66 (disability criteria restrict access [to SSI] of children with multiple impairments). This inherent deficiency of the listings was acknowledged at the 1959 *Disability Insurance Hearings* 342.

C. The Secretary's Listings-Only Approach Imposes A Standard Stricter Than Called For By Congress.

Had Congress intended to make children subject to a more stringent standard it easily could have done so. The Title II program for Disabled Widows and Widowers is just such a strict eligibility program, awarding benefits only to those who are precluded from performing "any gainful activity." 42 U.S.C. § 423(d)(2)(B). See H.R. Conf. Rep. No. 1030, 90th Cong., 1st Sess., reprinted in 1967 U.S. Code, Cong. Admin. News 3179, 3197 ("more restrictive definition of disability"). The Secretary has long had regulations that require widows and widowers to meet or equal the listings if they are to be considered disabled. 20 C.F.R. § 404.1526; see also *Yuckert*, 482 U.S. at 164 n.3 (Blackmun, J., dissenting).

The Secretary has explicitly recognized that by limiting both widows and children to a listings-only test, he imposes the "any gainful activity" threshold of severity:

The level of severity of an impairment which a title II widow(er) or a title XVI child must meet or equal to be determined to be under a disability is that which is considered under the regulations to be sufficient to preclude engaging in *any gainful activity* (i.e., must meet or equal the Listings), as distinguished from SGA. The concept of "gainful activity," however, is used only in setting the requisite level of severity of the impairment in the Listing of Impairments and not otherwise.

SSA, POMS DI 00401.336 (J.A. 259) (emphasis in original).²⁴ There can be no doubt that the listings embody a level of severity that precludes "any gainful activity" and not just "substantial gainful activity." *Campbell*, 461 U.S. at 460; *Tolany v. Heckler*, 756 F.2d 268, 270-71 (2d Cir. 1985). The exclusive use of the listings, then, not only denies functional

²⁴ See also 50 Fed. Reg. 50118, 50120 (1985), contrasting general termination of benefits standard—ability "to engage in SGA"—with that of widow(er)s and SSI disabled children, where SSA "need only show the capacity to engage in gainful activity."

assessments but requires a level of severity higher than that legislated by Congress. Had Congress intended for children to meet such a standard, it easily could have required children to be found disabled only if they had impairments of "comparable severity to a disabled widow." Although Congress set a standard that compares children's impairments to those of disabled adults, and not disabled widows, the Secretary has distorted this congressional language to make children conform to the much stricter standard. However, the Secretary is not free to substitute his own judgment for that of Congress. Congress made a deliberate choice and must be presumed to have known what it was doing. *Schweiker v. Hogan*, 457 U.S. at 587.

In sum, the Secretary's listings-only approach for determining disability fails to meet the express intention of Congress that children be given the opportunity to show that they suffer from "any" impairment of "comparable severity" to one which would actually, even if not presumptively, disable an adult.

II. THE SECRETARY'S POLICY OF DENYING INDIVIDUALIZED FUNCTIONAL ASSESSMENTS FOR IMPAIRED CHILDREN HAS NOT BEEN CONSISTENT OR CONTEMPORANEOUS, NOR HAS IT BEEN APPROVED BY CONGRESS.

The Secretary has argued that his implementation of § 1614(a)(3) has been consistent and clear from the earliest days of the SSI program. From this assertion, he makes two interrelated arguments. First, he argues that his interpretation was contemporaneous and has been consistent, and therefore it is entitled to considerable deference. Second, he argues that Congress knew of and approved his interpretation either (1) when it enacted § 501 of the Unemployment Compensation Amendments of 1976, Pub.L. No. 94-566, 90 Stat. 2667, 2685, which ordered the Secretary, *inter alia*, to promulgate long-delayed criteria for adjudicating the disability of children or, in the alternative, (2) through its silence. These arguments are baseless; the Secretary's position has been anything but consistent and, under established principles of statutory con-

tent and, under established principles of statutory construction, it is not entitled to special deference. Further, given these inconsistencies, Congress could not have been aware of, let alone approved, the rigid listings-only policy that eventually evolved. Indeed, much of the policy was either nonexistent or not available to Congress, making it impossible for Congress to have known that it was approving the Secretary's policies as they have now come to exist.

A. The Secretary Has Been Inconsistent In His Interpretation Of The Statute

There are at least four major areas where the Secretary has changed his policy or taken an inconsistent position. First, and perhaps most importantly, the Secretary at first adopted, and then rejected, the need for a working definition of the "comparable severity" standard. Second, the Secretary has taken an ambiguous and shifting position on the need to evaluate functional limitations for children. Third, the Secretary has taken the position, most fully articulated in this litigation, that an assessment of residual functional capacity, for children or adults, is not a *medical* determination, thereby contradicting his own regulation (20 C.F.R. § 416.945). Fourth, the Secretary has reversed himself on the importance of the role of equivalence in the disability adjudication process, stripping it of the flexibility it once had, as applied to both child and adult claimants.

1. Inconsistency On The Need For A Working Definition Of "Comparable Severity"

At the inception of the SSI program, the Secretary issued the two policy statements ("Disability Insurance Letters" or "DILs") that were to be the basis for deciding childhood disability claims. (J.A. 89, 94). The first DIL stated that "disability in children must be defined in terms of the primary activity in which they engage, namely growth and development, the process of maturation." (J.A. 90).

ments and also promised a regulatory definition of the phrase "impairment of comparable severity" (J.A. 95), noting that "[n]ot all children's impairments will lend themselves to formal codification." (J.A. 97). His recognition of the need for a working definition of "comparable severity" was a recognition that non-listed impairments in children, as in adults, could be disabling even when no listing was met or equaled. Obviously, if the listings were to be the end of the inquiry, such a definition would hardly have been needed. On the other hand, if adjudicators were going to make flexible, individualized assessments of functional capacity in children, such a definition as the Secretary promised to produce would be essential.

By 1977, however, when he promulgated the long-awaited final regulations, the Secretary had reversed himself. One searches the regulations in vain for any workable definition of comparable severity. The only mention of comparability comes not in the regulations themselves but in the preamble, where the Secretary explained that he had tried to equalize the average level of severity in the adult listings and the child listings.²⁵ 42 Fed. Reg. 14705 (1977). However, far from putting children on an equal footing with adult claimants, such equalization simply prevented "transitional problems," i.e., a child who met the child listings would automatically meet the adult listings. *Id.* Totally abandoned was the notion that children would be adjudicated using a standard comparable to that by which an adult is adjudicated.

2. Inconsistency On The Relevance Of Functional Evidence

The Secretary has exhibited an ambiguous and contradictory approach toward the evaluation of functional limitation in children. However, the question of whether an impairment is

²⁵ Indeed, several of the 57 child listings were taken verbatim from the adult listing, or were modified only by a word or two. *E.g.*, §§ 102.02, 102.08, 107.5, 107.11, 111.02 and 111.05.

disabling is a question of functional limitation.²⁶ Consistent with this overriding principle, the Secretary's initial policy, as embodied in the 1974 DIL, emphasized the need to seek out "adverse factors of learning and behavior" to see whether there were any impairments in intellectual, social and emotional developmental progression (i.e., impairments which did not "lend themselves to formal codification") in addition to those contained in the listings. (J.A. 97-98). It also directed adjudicators to look to "growth—increase in size and maturation of physical and functional characteristics, learning, mastering basic skills and emotional and social development" (J.A. 96), all measures of functional limitation. These instructions clearly acknowledged the need to ascertain how the ability to function in primary activities for adults and children could be determined so that comparisons could be made. The overall goal, then, was to compare the *impact* of the impairment on the child's life with that of the impact of a similar impairment upon an adult's life. (J.A. 96). This was clearly a functional approach.

But by 1977, the Secretary had retreated from his earlier position. The preamble to the final regulations asserts that severity must be assessed in "medical rather than functional terms" and that consideration of "[d]evelopmental needs . . . such as counseling, special education, training, rehabilitation, guidance, etc. are not within the scope of the law." 42 Fed. Reg. at 14706.

The Secretary sounds a similar note in his brief, imposing an explicit methodology that relies on "medical factors alone"

²⁶ Medical professionals can diagnose the impairment and even predict some of the kinds of likely limitations. However, human experience is varied. A medical condition that would leave one person confined to a wheelchair and unable to work might not lead to any discernible functional limitation in the case of President Roosevelt. Thus, "[t]he Social Security Act defines 'disability' in terms of the effect a physical or mental impairment has on a person's ability to function" *Campbell*, 461 U.S. at 459-60. *Only* impaired ability to function results in disability.

(Pet. Br. 38), precluding evidence "on the individual child's ability to function as such" (*id.* 42), and denying the workability and even the legality of evaluating children in terms of "age appropriate activities." (*Id.* 44). Having abandoned a broad approach that sought to gather as much evidence of functional limitation as practically possible, since 1977 the Secretary has adhered to a policy that considers functional limitation only where explicitly allowed by a handful of individual listings and then only in the crabbed terms allowed by the particular listing. (*Id.* 42).

3. Inconsistency On The Nature Of The RFC Assessment

A related inconsistency has been the Secretary's artificial distinction between "medical" and functional evidence and his denial that his inquiry into an adult's residual functional capacity is a medical determination, in order to support his contention that such an inquiry is inappropriate for children.²⁷ Such a distinction was also made in the Secretary's 1977 rulemaking, where he attempted to justify his listings-only approach on the grounds that he was obligated to look only at medical factors, which he equated with the listings, as if no other medical evidence were relevant. 42 Fed. Reg. at 14706. Such a position is markedly different from that taken in the earlier Disability Insurance Letters, which called for a full development of evidence beyond the listings.

Cast aside in the Secretary's later policies were the very first instructions of September 1973 emphasizing that "abnormalities" in function *cannot* always be fully demonstrated by clinical and laboratory diagnostic techniques (J.A. 97-98), thus necessitating inclusion of "adverse factors of learning and

²⁷ The Secretary attempts to distinguish what he terms the "medical" evidence called for in the listings and all other evidence of disability, which is usually referred to in pejorative terms, *e.g.*, "amorphous . . . unspecified non-medical factors." (Pet. Br. 15).

behavior." (*Id.*). In the 1973 DIL, the Secretary defined medical factors broadly to include "a child's activities, behavioral adjustment, and school achievement." (J.A. 91). *See also* 1974 DIL (J.A. 97-98). In 1977, the Secretary reversed himself, excluding functional impact indicators such as the need for special education as "not within the scope of the law." 42 Fed. Reg. 14706. Thus, Joseph Love, a maladjusted ten year old with organic brain syndrome, who failed first grade three times and was removed from a special education class (J.A. 50), would, under the earlier policies, have had his educational failures and need for special education assessed; however, under the later listings-only policy he could not have his need and evidence of behavioral disorders taken into account.²⁸

By imputing a skewed, overly restrictive meaning to the term "medical," contrary to established medical thought and practice, *see* Am. Br. of A.M.A. and Amer. Acad. of Pediatrics *et al.*, as well as his own original interpretation of the term, the Secretary has foreclosed realistic assessments of children. His methodology has guaranteed that, however dysfunctional a child was, such dysfunction could not be taken into account, while similar dysfunction would be taken into account in adult disability determinations at the RFC stage. *City of New York*, 476 U.S. at 471.

The Secretary's litigation position on the nature of the adult RFC assessment is even inconsistent with his own regulations, which state that "[r]esidual functional capacity is a medical assessment," 20 C.F.R. § 416.945(a), that also allows the consideration of testimony regarding symptoms beyond those necessary for diagnosis. Although limitations such as pain and

²⁸ Since his brief to this Court was written, the Secretary has again changed his position on the relevance of the need for "special education." Now, in his proposed rulemaking, the Secretary has *endorsed* inquiry into this need and declared "special education" evidence to be "medical evidence" rather than "supplemental data." 54 Fed. Reg. 33242 (1989).

other subjective complaints are not part of the listings, they are decidedly part of the overall medical assessment of disability. 42 U.S.C. § 1382c(a)(3)(F) (Supp. IV 1986). Indeed, if they were not so assessable, it is difficult to see how the Secretary could take them into account, given the statutory mandate for medical determinations, 42 U.S.C. § 1382c(a)(3)(C).

The Secretary's third inconsistency, then, is in considering such limitations for adults in the admittedly "medical" determination of RFC, while asserting that he is legally precluded from doing so for children on the grounds that such determinations are, for them, "non-medical." (Pet. Br. 15, 28, 33, 38); see also 43 Fed. Reg. 55349 (1978) ("medical considerations alone" used for SSI child claimants); 45 Fed. Reg. 55570-71 (1980) (children "to be assessed only in medical terms").

4. Inconsistent Interpretation Of "Equivalence"

The final inconsistency that precludes deference to the Secretary's listings-only approach is the dramatic change in the role of equivalence in childhood disability determinations. Early in the program, the Secretary took a flexible view of equivalence and encouraged adjudicators to rely "heavily" upon equivalence to decide difficult cases. (J.A. 97). Not only would equivalence play an important role where no particular listing applied, but adjudicators were directed to use the equivalency concept in multiple impairment cases where each impairment fell short of the relevant listing. (*Id.*) In such cases, the combined effect on major daily activities of each impairment was to be taken into account to determine whether the combination of impairments equalled a listed impairment. (*Id.*).

This flexible approach was later jettisoned when the Secretary adopted SSR 83-19.²⁹ That Ruling rejected the earlier

²⁹ Beginning almost immediately, "equivalence" findings began to drop precipitously, to the extent that such a finding became an anomaly. Comm. on Ways and Means, 101st Cong., 1st Sess., *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, Sec. II, Table 2 (Comm. Print 1989).

formulations, stating that "it is incorrect to consider whether the listing is equalled on the basis of an assessment of overall functional impairment The functional consequences of the impairments (i.e., RFC), irrespective of their nature or extent, cannot justify a determination of equivalence." SSR 83-19 (J.A. 239-40) (emphasis in original). Thus, there can never be an "equals" decision based on an individualized assessment of functional limitations, however "severe" the limitations, for either an unlisted impairment or a combination of them. This posture prohibited any meaningful inquiry into functional limitation, and marked a major departure from previous policy.

B. The Secretary's Current Interpretation Is Not Due Any Special Deference Because Of His Inconsistencies.

Because the Secretary's interpretation of the statutory provision at issue has changed over the years, his construction loses the deference to which it would otherwise be entitled as an agency's interpretation of legislation it is charged with implementing. *I.N.S. v. Cardoza-Fonseca*, 480 U.S. at 446 n.30; *Watt v. Alaska*, 451 U.S. 259, 272-73 (1981); *General Electric Co. v. Gilbert*, 429 U.S. 125, 143 (1976). The Court has on more than one occasion declined to grant any special deference to the HHS (or HEW) Secretary's interpretation of a statute he was charged with implementing, precisely because his interpretation had "evolved" over time. See *Bowen v. American Hospital Ass'n*, 476 U.S. 610, 645-46 & n.34, (1986) ("AHA") (plurality opinion); *Southeastern Community College v. Davis*, 442 U.S. 397, 411 n.11 (1979).

An agency's current interpretation of a statute need not be directly contrary to its prior construction to deprive the later construction of the deference normally afforded. Administrative interpretations which have "evolved" over time also lose the deference to which they would otherwise be entitled. See, e.g., *AHA*, 476 U.S. at 645-46; *American Mining Congress v. EPA*, 824 F.2d 1177, 1179 (D.C. Cir. 1987).

An agency which has taken a "somewhat inconsistent posture" will not be given any special deference with respect to its

current interpretation of a statute. See *Morton v. Ruiz*, 415 U.S. 199, 237 (1974). This includes situations where the agency's interpretation of a given statutory provision changed from a broad one to a more narrow one, see, e.g., *American Mining Congress*, 824 F.2d at 1181-82, or has changed from a narrow one to a broader one, see, e.g., *Barnett v. Weinberger*, 818 F.2d 953, 960-61 (D.C. Cir. 1987). It also includes situations where the agency's interpretation has been "erratic." See *Cardoza-Fonseca*, 480 U.S. at 447 n.30.

Ultimately, the question to be asked is not whether there has been a total reversal in administrative construction, which is rare, but rather whether the agency's current interpretation, in regulations or in its litigation posture, constitutes a "significant change" from that taken by the agency previously. Compare *Fed. Elec. Comm'n v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 38 (1981), and *EEOC v. Associated Dry Goods Corp.*, 449 U.S. 590, 600 n.17 (1981), with *Barnett v. Weinberger*, 818 F.2d at 961-62 (administrative interpretation of statutory term "custodial care" was changed "in a significant way," and therefore did "not merit a substantial degree of respect").

Under these standards, the inconsistency in the Secretary's various positions deprives his current position of any special deference that it would otherwise be due. These inconsistencies are at least as significant as the inconsistencies which this Court has noted in refusing to grant special deference to various agencies' later statutory constructions. For example, in *Southeastern Community College*, the Court refused to give any special deference to the Secretary's construction of § 504 of the Rehabilitation Act of 1973 as authorizing him to promulgate regulations requiring recipients of federal funds to undertake affirmative action to accommodate handicapped individuals, because, for the first three years after the statute was enacted, "HEW [now HHS] maintained the position that Congress had not intended any regulations to be issued." 442 U.S. at 412 n.11. The Secretary had never issued regulations contradicting

the regulations at issue, but had simply taken the position, earlier on, that *no* regulations were authorized.

In this case, the Secretary originally saw the statute as requiring something beyond a listings-only approach (J.A. 95, 97) and, as we shall see, *infra*, pp. 37-38, even "led Congress to believe" that this was his interpretation, *Morton v. Ruiz*, 415 U.S. at 237. After Congress ordered him to publish *some* standards for assessing children's SSI disability claims, the Secretary responded only with the listings, asserting that this was all that was required. This hardly constitutes the "consistent" approach from "the outset of the SSI program" suggested by the Secretary in his brief. (Pet. Br. 17). Rather, as in *Southeastern Community College*, the fact that the agency has "altered its stand . . . substantially diminishes the deference to be given to [its] present interpretation of the statute." 442 U.S. at 412 n.11.

In *AHA*, 476 U.S. at 645-46, a plurality of the Court found inappropriate the granting of any special deference to regulations designed to insure hospitals' provision of medical care to severely handicapped newborns, because the Secretary's regulations, while not directly inconsistent with previous constructions, had "evolved" over a two year period. Similarly, in his 1974 DIL (J.A. 94), the Secretary recognized that the provisions for children's disability "will require not only the development of additional more specific criteria, but also a definition of the phrase 'impairment of comparable severity,'" thus clearly implying that "comparable severity" could not be fully addressed by the listings alone. Nevertheless, in his subsequent promulgation of "criteria" for assessing childhood disability claims, he adopted a listings-only approach, thereby rejecting by omission the need for any definition of "impairment of comparable severity" going beyond the listings. As in *AHA*, 476 U.S. at 646, such inconsistency deprives the Secretary's current position of any special deference.

Finally, in *Cardoza-Fonseca*, this Court rejected the Government's position that two different statutory standards,

applicable to aliens' requests for relief from deportation on the basis of threatened persecution, were identical. In so doing, the Court rejected the Government's contention that its position was entitled to heightened deference as an administrative construction, because of the "inconsistency of the positions the BIA [Board of Immigration Appeals] has taken through the years," noting that "[t]he BIA has answered the question . . . in at least three ways." 480 U.S. at 446-47 n.30. As in *Cardoza-Fonseca*, the Secretary's construction of the "comparable severity" provision "has not consistently agreed with" his current litigation position.

C. Congress Has Not Approved The Secretary's Construction; Rather Its Action Suggests Disapproval.

The Secretary argues that Congress has expressed its "approval" of his current interpretation of the statute by the requirement, in § 501(b) of the Unemployment Compensation Amendments of 1976, that the Secretary promulgate criteria to be employed in determining disability under 42 U.S.C. § 1382c(a)(3). However, this Court has specifically noted that "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *Jefferson County Pharmaceutical Ass'n, Inc. v. Abbott Laboratories*, 460 U.S. 150, 165 n.27 (1983). For the Court to find congressional approval, there must be full knowledge by the entire Congress of the administrative construction of the earlier statute at the time the second act was passed, and there must have been some affirmative indication of approval by the subsequent Congress. *TVA v. Hill*, 437 U.S. 153, 192 (1978). No such approval has ever been given by Congress to the narrow listings-only interpretation, nor was Congress aware of the Secretary's interpretation at any time that it was considering making, or in fact made, amendments to the original legislation. Under these circumstances, congressional inaction is of little if any significance as a factor supporting the Secretary's interpretation. See *SEC v. Sloan*, 436 U.S. 103, 120-21 (1978).

1. The 1976 UCA Did Not Ratify The Secretary's Current Policy.

Far from constituting "express approval" of existing SSA policy, the legislative history of the Unemployment Compensation Amendments of 1976 shows that Congress was extremely dissatisfied with the Secretary's approach to the SSI children's disability program, and with his inaction. Contrary to the Secretary's representations (Pet. Br. 30), both Congress and SSA recognized that the situation was chaotic because the Secretary had failed to publish any detailed guidelines for the adjudication of childhood disability. A blue ribbon "Study Group" recommended legislation to create "a more specific definition for disability of a child," that would take into account the developmental nature of many childhood impairments. *Oversight of the Supplemental Security Income Program: Hearings Before the Subcomm. on Oversight of the House Comm. on Ways and Means*, 94th Cong., 2d Sess. 21 (1976) (hereinafter, "1976 Hearings"). Commissioner Cardwell told Congress that it was important to remedy the difficulty and inequity that had been experienced by children. *Id.*

Ultimately, the Secretary told Congress that he agreed with the Study Group's concern, but denied the need for legislation. The two DILs (J.A. 89, 94), the Secretary claimed to Congress, formed the basis for clearing up the difficulty and unfairness that had arisen from the lack of coordination. *1976 Hearings* at 22. Congress relied upon these two policy statements in passing the UCA. See *Supplemental Security Income Program: Hearings Before the Subcomm. on Public Assistance of the House Comm. on Ways and Means*, 94th Cong., 1st Sess. 781-82 (1975).

The two DILs called for a review that was much closer to the individualized determination enjoyed by adults. The September 1973 DIL, which drew on the experience gained in the Title II Child Disability program (J.A. 89), stated that "disability in children must be defined in terms of the primary activity in which they engage, namely growth and develop-

ment, the process of maturation" (J.A. 90), and therefore called for the gathering of evidence of functional limitations. (J.A. 91). As noted above the 1974 DIL also promised a definition of comparability. (J.A. 95).

The Secretary argued in 1976 that legislation was unnecessary, but Congress, surveying the SSI program, was not pleased. Two years after the program began, Listings of Impairments for children had not yet even been published, nor had any work been done to further define "comparable severity" or to explain how an equivalence determination was to be made.

Utilizing the language of the DILs, Representative Mikva of the Ways and Means Committee proposed an amendment to H.R. 8911 to mandate publication of criteria for determining disability:

The amendment mandates that this criteria take into account not only the medical development of the child but also the child's social, educational, and personal development. . . .

. . .

[T]he assessment should refer to the impact of the child's handicap on his ability to function successfully within age-appropriate expectations. The child's functional capacity within the areas of learning, language, self-help skills, mobility, and social skills are decidedly more meaningful in determining both the severity of his impairment and his developmental potential.

In addition to the development of specific and standardized disability criteria for children, guidelines should be established in order to obtain the existent information, such as school records and developmental assessments, required to evaluate effectively a child's functional capacity.

122 Cong. Rec. 27855 (1976). The amendment³⁰ passed easily and went to the Senate.

In the same session, Senator Hathaway, a member of the Senate Finance Committee, described the similar Senate amendment that eventually was adopted, using language very similar to the DILs:

This test of comparable severity for a child's disability is required in current law. Like the test for determining the disability of an adult, a disability is not determined solely on medical grounds but also includes an evaluation of the impact of the disability on the person's abilities The assessment, rather, should refer to the impact of the child's handicap on his ability to function successfully within age appropriate expectations. The child's functional capacity within the areas of learning, language, self-help skills, mobility and social skills are decidedly more meaningful in determining both the severity of the impairment and the developmental potential of the child.

122 Cong. Rec. 34026 (1976). Further, Senator Hathaway viewed medical criteria expansively:

Medical criteria used in the broad sense of the total health development of the child could indeed provide the basis for determining the comparable severity of a child's disability. Medical criteria which are restrictively drawn . . . are not going to provide a definition of disability relevant to the person under the age of 18. A test of comparable severity is needed and is required in the present definition of disability for such persons. . . .

³⁰ The provision in H.R. 8911 stated:

(e) The Secretary shall, within 120 days after the enactment of this subsection, promulgate by regulation criteria (including medical, social, personal, educational, and other criteria) for the determination of disability in the case of persons who have not attained the age of 18.

94th Cong., 2d Sess., 122 Cong. Rec. 27853 (1976).

Id. Senator Hathaway certainly did not endorse a listings-only approach. Senator Bentsen, also a member of the Finance Committee, criticized the Secretary's failure even to notice the SSI children's program. 122 Cong. Rec. 33301 (1976). The Senate version of the bill was enacted.³¹

The basis of the Secretary's argument for congressional approval ignores this legislative history and focuses on the Senate report accompanying the UCA. S. Rep. No. 1265, 94th Cong., 2d Sess. 24, reprinted in 1976 U.S. Code, Cong. Admin. News 5997, 6018. That report did indeed note that the Secretary had a regulation that called for children to meet a listing or satisfy a broad equivalency test. *Id.* The report, however, was critical of the Secretary, calling his existing guidelines inadequate. *Id.* The report's observation that, while SSA had issued several statements on the program, no specific guidelines had been sent out for the state agencies to follow, *id.*, is a strong indication that the Senate expected more than a listings-only program, as the 1974 DIL already contained listings adapted for children. (J.A. 104-14). Rather than approving the Secretary's regulation, the Senate report focused on the Secretary's shortcomings and reflected general congressional dissatisfaction. Promised but undelivered policies on the definition of comparable severity (J.A. 95), and the "compilation of data on 'developmental milestones'" (J.A. 98), were what Congress wanted.

At a minimum, in order to support a conclusion that Congress has approved an administrative construction of a statute,

³¹ Senator Bentsen assured his colleagues that the House saw no functional difference between the two provisions, 122 Cong. Rec. 33301-02; the House Conference Committee did not think the two versions dissimilar enough to warrant comment. H.R. Conf. Rep. No. 1745, 94th Cong., 2d Sess. 22, reprinted in 1976 U.S. Code, Cong. Admin. News 6032, 6046. Thus, Congress was of one mind that the Secretary's performance was deficient and that individualized determinations based on the impact of impairments were appropriate under the existing comparable severity standard.

the entire Congress must have been made fully aware of that construction and of the issue of its possible inconsistency with the statutory provision, when it was making other amendments. *Zuber v. Allen*, 396 U.S. 168, 185 n.21, 193 (1969); *Bob Jones University v. United States*, 461 U.S. 574, 599-601 (1983); *United States v. Rutherford*, 442 U.S. 544, 554 n.10 (1979). The Senate report cited by the Secretary did not mention whether the Secretary's regulations could be construed as limiting children to an evaluation under the listings, or the issue of whether, if they could be so construed, they might be inconsistent with the statute; nor did it express any opinion whatsoever on the wisdom of those regulations. From this one report, no general congressional awareness of the Secretary's restrictive construction can be inferred. See *Sloan*, 436 U.S. at 120-21. See also *Blanchard v. Bergeron*, — U.S. —, 109 S.Ct. 939, 947 (1989) (Scalia, J., concurring).³²

A more fundamental problem with the Secretary's contention of "general congressional awareness" of his construction of the statute lies in its evolution over time. In 1976, the Secretary's only published statement on this issue, as paraphrased in the Senate Finance Committee report, was 20 C.F.R. § 416.904 (1975), which referred to satisfaction of the listings or medical equivalence to a listed impairment. However, as noted above, the DILs clearly stated that more than just a listings approach

³² Furthermore, even if the Senate Finance Committee report could be said to provide some evidence of limited congressional awareness in 1976 of the Secretary's developing construction of the statute, it is impermissible to infer from this one report that the entire Congress was aware of this construction and its possible inconsistency with the statute. As explained in *Sloan*:

[W]hile it appears that the Committee Report did recognize and approve of the Commission's practice, this is scarcely the sort of congressional approval referred to in *Zuber*. . . .

436 U.S. at 121. Compare *Yuckert*, 482 U.S. At 151-52 (explicit endorsement in all three legislative reports).

would be utilized and that equivalence would be applied flexibly.

It was entirely reasonable in 1976 for Congress, following the Secretary's interpretation, to consider "medical equivalence" as allowing any impairment or combination of impairments to be individually assessed for functional consequences of "comparable severity." Accordingly, even if Congress had "approved" the Secretary's then-applicable policies when it passed the UCA in 1976, it could not have been aware of the Secretary's later shift in policy that precluded equivalency based on functional limitations.

In sum, rather than enshrining the Secretary's nascent listings-only approach, Congress was concerned in 1976 that children receive realistic determinations and wanted the Secretary to end the confusion by promulgating regulations that made good on his promises and assurances. The language used by the provision's prime sponsors, Representative Mikva and Senators Bentsen and Hathaway, goes well beyond a listings-only approach, as did SSA's early policy.

2. Congress Has Not Approved The Secretary's Current Interpretation Through Inaction.

The Secretary further argues that, even if the UCA did not constitute congressional approval of his policy, Congress' subsequent inaction has constituted such approval. Citing *Schwelker v. Chilicky*, ___ U.S. ___, 108 S.Ct. 2460 (1988), and *Yuckert*, he argues that there was "comprehensive congressional oversight" of the SSI disability standards. (Pet. Br. 34-35). An exception to the requirement of express approval may apply where the administrative interpretation of a statute has clearly and repeatedly been brought to the attention of Congress through its oversight function, and Congress nevertheless has refused to correct that interpretation. See, e.g., *Heckler v. Day*, 467 U.S. 104, 111-15 (1984); *Bob Jones University*, 461 U.S. at 600-01. However, at a minimum, it must be shown that Congress, although repeatedly having been

informed of the agency's construction and having taken no action thereon, at least considered the propriety of the specific administrative ~~s~~utory construction at issue.³³

Whatever "oversight" can be said generally to have existed over the Social Security Administration's programs, Congress as a whole has not addressed itself to the particular interpretation at issue. Indeed, the children's SSI disability program has been marked by relative invisibility to a Congress that has been primarily concerned with the much larger, and more controversial, adult Social Security programs.

III. THE SECRETARY ALREADY HAS DEVELOPED WORKABLE STANDARDS TO INSTITUTE INDIVIDUALIZED FUNCTIONAL ASSESSMENTS OF CHILDREN.

The Secretary repeatedly asserts that a functional assessment of impairments comparable to the RFC evaluation given adults is impossible because children are too young to be compared to those in the work force. He argues, in particular, that "there is no analogous benchmark [to the ability-to-work criterion] that can feasibly be adopted for use with children" such as "ability to engage in age-appropriate activities." (Pet. Br. 44). However, his past policy pronouncements, his policy of performing RFC assessments in the Title II Child Disability insurance program, his criteria for determining when to terminate SSI benefits for children, 20 C.F.R. § 416.994, and his recent revisions to the children's mental impairment listings all belie that contention.

³³ Such was clearly the case in *Day*, where the Court noted that Congress had taken up the question of the Secretary's delay almost annually, but attempts at passing mandatory deadlines repeatedly had been rejected. 467 U.S. at 118 n.30. Compare *Aaron v. SEC*, 446 U.S. 680, 694 n.11 (1980) (Congress' inaction after having twice been expressly informed of Commission's interpretation insufficient basis to presume congressional approval where "legislative consideration of those statutes was addressed principally to [other] matters. . .").

First, at several points the Secretary has used a standard that analogizes the ability to engage in age-appropriate activities to ability to perform substantial gainful activity. In explaining the formulation of a "comparable severity" test, he initially stated:

[I]t is necessary to define how the ability to function in primary activities appropriate for adults and children may be determined This term ["disability"], when applied to children, cannot properly be associated with an inability to work [D]isability in children must be defined in terms of the primary activity in which they engage, namely growth and development, the process of maturation.

1973 DIL (J.A. 90). Thus the Secretary recognized the relevance, indeed the necessity, of a functional test geared to the developmental progress of the child. That the Secretary contemplated evaluation of daily functioning relevant to the child's life is shown by his extensive explanation of the need to evaluate the "adverse factors of learning and behavior" to address realistically the "significant number of children [who] are impaired in their intellectual, social, and emotional development progression." 1974 DIL (J.A. 97-98).

Second, although the Secretary argues strenuously that RFC determinations for children are impossible, since 1956 he has administered the Title II Child Disability insurance benefit program, under which benefits are paid to children of dead, disabled or retired workers, who become disabled in childhood. 42 U.S.C. § 402(d) (1982 & Supp. IV 1986); 20 C.F.R. § 404.350. This program evaluates disability in the childhood years using the same definition of disability and five-step sequential evaluation process as that used for disabled adult workers. 42 U.S.C. § 402(d)(1)(G) (Supp. IV 1986); 20 C.F.R. § 404.1511(a). See also *Allegra v. Bowen*, 670 F. Supp. 465, 467 (E.D.N.Y. 1987) (the "Secretary uses a five-step sequence to evaluate [such] disability claims"). This broad functional assessment comports with Congress' anticipation that such functional indicators as "school and other records" of children would be utilized in these

evaluations. S. Rep. No. 2133, 84th Cong., 2d Sess., reprinted in 1956 U.S. Code, Cong. Admin. News 3877, 3882.

Third, although the Secretary pejoratively describes "age-appropriate activities" as "amorphous," "not . . . workable," and with "no foundation in the . . . statute" (Pet. Br. 44), his own SSI regulations expressly employ this term as the child's equivalent of an adult's "ability to work." In regulations promulgated pursuant to § 2 of the Social Security Disability Benefits Reform Act of 1984, 42 U.S.C. § 423(f), the Secretary sets out his standard for determining whether a beneficiary has ceased to be disabled. 20 C.F.R. § 416.994. In the subsection governing SSI children's cases, the Secretary states that he first determines whether "medical improvement" exists and, if so, whether this "is related to your ability to work (i.e., your ability to perform age-appropriate activities)." § 416.994(c) (emphasis added). The regulation further provides that, when medical improvement occurs, and the severity of the prior impairment(s) no longer meets or equals the listings, "we will find that the medical improvement was related to your ability to work (i.e., your ability to perform age-appropriate activities)." § 416.994(c)(1)(ii). In short, the Secretary explicitly recognizes that his review policies for SSI child beneficiaries assess the equivalent of "work" abilities, specifically equating them to "age-appropriate activities"; yet he argues vociferously that such formulations are totally inappropriate, unworkable and with "no foundation in the . . . statute." (Pet. Br. 44).

In addition, the newly proposed "Mental Disorders in Children" listings, 54 Fed. Reg. 33238 (1989), further undercut the argument that it is not "feasible" to use age-appropriate activity as a viable "benchmark." (Pet. Br. 43-44). In this proposal, the Secretary specifically accepts the ability to engage in age-appropriate activity as one of the primary determinants of disability. 54 Fed. Reg. at 33242.

Further, in his newly proposed listings the Secretary has taken a much more functional approach. As part of that approach, the Secretary plans to use deficiencies in concentra-

tion, persistence or pace resulting in "frequent failure to complete work-like tasks in a timely manner" as one of four indicia of functional impairment. See proposed § 112.02(B)(2)(d), 54 Fed. Reg. at 33244. In addition, the Secretary has decided that because Personality Disorders "do not usually manifest themselves until later in childhood," 54 Fed. Reg. at 33240, all such children should be evaluated under the adult listing, § 12.08. One of the four functional indicia in that listing is "deterioration or decompensation in work or work-like settings." § 12.08 (B)(4). The Secretary obviously intends, then, to examine a child's performance in a "work-like setting." Thus, the new proposed regulations are patently inconsistent with the Secretary's position that children are so divorced from the work force that he cannot make RFC determinations for children or draw any useful analogies between children and disabled adults. (Pet. Br. 44).

Finally, functional assessments have long been part of the accepted diagnostic and treatment procedures in the medical community. Because functional assessments of the impact of a child's developmental, medical and behavior problems upon day-to-day activities are so critical to treatment, the medical community has made them an essential and "workable" part of medical practice. See Am. Br. of Amer. Acad. of Child & Adolescent Psychiatry, *Amer. Psychiatric Ass'n et al.*; Am. Br. of A.M.A., *Amer. Acad. of Pediatrics et al.*

The Secretary has at his disposal not only the practices of his own agency, but also the expertise of the established medical community. Thus the purported lack of available "benchmarks" cannot justify the Secretary's current policy.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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APPENDIX

APPENDIX

1. Section 1614(a)(3)(A) of the Social Security Act, as codified at 42 U.S.C. § 1382c(a)(3)(A) provides in pertinent part:

An individual shall be considered to be disabled . . . if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

2. Section 1614(a)(3)(F) of the Social Security Act, as codified at 42 U.S.C. § 1382c(a)(3)(F) (Supp. IV 1986) provides:

In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Secretary shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Secretary does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

3. 20 C.F.R. § 416.924 provides:

How we determine disability for a child under age 18.

We will find that a child under age 18 is disabled if he or she—

- (a) Is not doing any substantial gainful activity; and
- (b) Has a medically determinable physical or mental impairment(s) which compares in severity to any impairment(s) which would make an adult (a person age 18 or over) disabled. This requirement will be met when the impairment(s)—

- (1) Meets the duration requirement; and

(2) Is listed in Appendix 1 of Subpart P of Part 404 of this chapter; or

(3) Is determined by us to be medically equal to an impairment listed in Appendix 1 of Subpart P of Part 404 of this chapter.

4. 20 C.F.R. § 416.920a(c)(3) provides:

Evaluation of mental impairments.

If you have a severe [mental] impairment(s) but the impairment(s) neither meets nor equals the listings, we must then do a residual functional capacity assessment, unless you are claiming benefits as a disabled child.

5. 20 C.F.R. 416.925(a) provides in part:

Purpose of the Listing of Impairments.

The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity.

6. 20 C.F.R. § 416.945(a) provides in part:

Your residual functional capacity.

Your residual functional capacity is what you can still do despite your limitations. If you have more than one impairment, we will consider all of your impairments of which we are aware. We consider your capacity for various functions as described in the following paragraphs[:] (b) physical abilities, (c) mental impairments, and (d) other impairments. Residual functional capacity is a medical assessment. However, it may include descriptions (even your own) of limitations that go beyond the symptoms that are important in the diagnosis and treatment of your medical condition [U]sing the guidelines in §§ 416.960 through 416.969, your vocational background is considered along with your residual functional capacity in arriving at a disability decision.

7. 20 C.F.R. § 416.994(c) provides:

Disabled persons under age 18 (children).

If you are entitled to disability benefits as a disabled child under age 18, there are a number of factors we consider in deciding whether your disability continues. We must determine if there has been any medical improvement in your impairment(s) and, if so, whether this medical improvement is related to your ability to work (i.e., your ability to perform age-appropriate activities) If medical improvement related to your ability to work has not occurred and no exception applies, your benefits will continue. Even where medical improvement related to your ability to work has occurred or an exception applies (see paragraph (c)(4) of this section for exceptions) in most cases before we can find that you are no longer disabled, we must also show, based on current medical evidence, that you no longer suffer from any medically determinable physical or mental impairment(s) of comparable severity to any impairment(s) which would make an adult disabled. As set out in § 416.923, this will be determined based on whether or not your impairment(s) meets or equals the requirements in Appendix 1 of Subpart P of Part 404 of this chapter.

8. SSA, Program Operations Manual System, DI 00401.335, provides:

Inability To Engage In Any Gainful Activity: Title II Widow, Widower or Surviving Divorced Spouse/Title XVI Child Under Age 18

In the Listing of Impairments, the regulations describe impairments of a level of severity deemed to preclude an individual from engaging in *any* gainful activity. An applicant for title II disabled widow's, widower's, or surviving divorced spouse's benefits or title XVI child's benefits *must* have an impairment(s) that meets or equals an impairment in the Listing.

As in the case of a title II worker or CDB [Child Disability Benefits] applicant or a title XVI claimant age 18 or older, a title II widow(er), or title XVI child whose work demonstrates ability to engage in SGA is *not* under a disability. The level of severity of an impairment which a title II widow(er) or a title XVI child must meet or equal to be determined to be under a disability

is that which is considered under the regulations to be sufficient to preclude engaging in *any gainful activity* (i.e., must meet or equal the Listings), as distinguished from SGA. The concept of "gainful activity," however, is used only in setting the requisite level of severity of the impairment in the Listing of Impairments and not otherwise.

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No. 88-1377

Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1989

LOUIS W. SULLIVAN, SECRETARY OF
HEALTH AND HUMAN SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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No. 88-1377

LOUIS W. SULLIVAN, SECRETARY OF
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REPLY BRIEF FOR THE PETITIONER

This case presents a single legal issue: whether the regulation requiring a claimant seeking SSI child's disability benefits to establish that he has an impairment that meets or equals the severity of a listed impairment (20 C.F.R. 416.924) exceeds the statutory authority of the Secretary of Health and Human Services and therefore is invalid on its face.

Respondents argue that the regulation conflicts with 42 U.S.C. 1382c(a)(3), which provides that a child is disabled if he has an impairment of "comparable severity" to one that would render an adult unable to engage in any substantial gainful activity. Indeed, according to respondents, Section 1382(a)(3) affirmatively requires the Secretary to follow a much different approach, namely: (1) to assess the "residual functional capacity" (RFC) of every child whose impairment does not meet or equal an impairment in Part A or Part B of the Listing of Impairments, and (2) to consider the child's RFC, together with unspecified non-medical factors (similar to the non-medical factors of age, education and work experience for an adult) to determine whether the child is disabled for purposes of Title XVI. Respondents' contention (Br. 15) that the Act "plainly" requires the evaluative approach they prefer is refuted by the rele-

vant statutory text. Section 1382c(a)(3)(A) makes no mention of the "residual functional capacity" of children, and Section 1382(a)(3)(B) makes no mention of any non-medical factors that must be considered for children—a significant omission in light of its express requirement that the non-medical factors of age, education and work experience be considered for adults.

By contrast, we have shown in our opening brief that the requirement that a claimant's impairment meet or equal the Listing is supported by the text, legislative history, and purposes of Section 1382c(a)(3)(A) (Gov't Br. 23-30, 37-41) and by Section 501(b) of the Unemployment Compensation Amendments of 1976 (90 Stat. 2685), which directed the Secretary to publish "criteria" to be employed "to determine disability" in children under age 18. Gov't Br. 24, 30-34. We also have shown that the Listing requirement has been an essential part of the child's disability program since its inception in January 1974, and that it incorporates functional considerations by identifying impairments that have an impact on development and growth in children that is comparable to the effect of impairments that prevent an adult from working. Gov't Br. 31-32, 36-40.

Respondents and their amici have failed to carry their heavy burden of overcoming this extensive support for the central regulatory requirement that has governed the adjudication of more than one million claims for child's disability benefits since the outset of the SSI program in 1974. Indeed, their submissions largely ignore the statutory support for the regulatory requirement and instead are devoted primarily to criticizing various aspects of the Listing itself or the way in which it has been applied to particular diseases or even to particular claimants. Those matters are beyond the scope of this suit, which was brought as a facial challenge to the Listing requirement.

A. Before addressing respondents' more specific legal arguments, we shall seek to correct several basic errors in respondents' brief about the operation of the disability programs for both children and adults. Respondents argue (Br. 15-24) that Part A and Part B of the Listing are divorced from "functional" considerations and prevent an "individualized" assessment of each claimant's condition, and they assume that their RFC approach could be substituted for the Listing approach with little disruption. Respondents are wrong in every respect.

1. The whole point of the Listing is to identify those impairments whose functional impacts are sufficiently severe to render a claimant disabled based on the presence of the impairment alone. Part B of the Listing, which sets forth additional children's impairments, is patterned after Part A, which is applied at step three of the sequential evaluation process for adults. See Gov't Br. 4-7. Part A is subdivided into categories of impairments affecting each principal body system (e.g., musculoskeletal, respiratory, cardiovascular, mental, neurological), and it identifies the "criteria" for each listed impairment (i.e., the medical signs, symptoms, and findings) that demonstrate the existence of an impairment of sufficient severity to deem the claimant to be disabled, without the need to consider his "vocational" factors of age, education, and work experience. 20 C.F.R. 416.925(a). Although the criteria are stated largely in medical terms, the requisite level of severity for each impairment was established on the basis of its functional consequences—its effect on the claimant's ability to perform work-related activities. Impairments are included in the Listing on the basis of the Secretary's judgment that they "are so severe as to preclude substantial gainful activity." *Bowen v. Yuckert*, 482 U.S. 137, 141 (1987); see also *Bowen v. City of New York*, 476 U.S. 467, 470-471 (1986) (impairments "of sufficient severity to preclude gainful employment"). And even if a claimant's impairment is not included in the Listing, he will be found disabled "if the medical findings are at least equal in severity and duration to the listed findings" (20 C.F.R. 416.926(a)). Thus, like the threshold severity regulation at issue in *Yuckert*, Part A of the Listing of Impairments "adopts precisely [the] functional approach to determining the effects of medical impairments" that was described in *Heckler v. Campbell*, 461 U.S. 458, 459-460 (1983). *Yuckert*, 482 U.S. at 146.

The same is true of Part B of the Listing, at issue here. Part B was formulated over a two-year period by medical specialists, including pediatricians, to identify impairments that compare in severity to those that render an adult unable to work. 20 C.F.R. 416.908, 416.924(b). The preamble to the publication of Part B in 1977 stated (42 Fed. Reg. 14,705) that in identifying the criteria that would establish disability—

these professionals placed primary emphasis on the effects of physical and mental impairments in children, the impact of the impairment on the child's activities, and the restrictions on growth, learning, and development imposed on the child by the impairments. Those impairments which were determined to impact on the child's development to the same extent that the adult criteria have on an adult's ability to engage in substantial gainful activity were deemed to be of 'comparable severity' to the adult listing.

As a result, the level of medical severity specified in Part B for each impairment was chosen precisely because it reflected the Secretary's judgment, informed by medical and other experts, regarding the impact of the impairment on a "child's activities" and his "growth, learning, and development."

Moreover, some of the individual listings require explicit functional assessments beyond that implicitly subsumed in the level of impairment severity generally. See §§ 101.03(C), 111.06, and 112.03, quoted at Gov't Br. 42. The recently proposed revision of the Part B mental impairment listing for children illustrates such an elaboration of the Listing approach in some detail. See 54 Fed. Reg. 33,238 (Aug. 14, 1989), reproduced at App., *infra*, 1a-26a.¹ The proposed listing for each of nine categories of mental disorders is divided into two paragraphs. The first identifies the clinical findings that are necessary to substantiate the existence of a mental disorder. The second paragraph then specifies the level of severity that must be shown in order for the impairment to be regarded as disabling; for that purpose, "severity is measured according to the functional limitations imposed by the medically determinable mental impairment." § 112.00C (Preamble); App., *infra*, 7a. To implement this principle, the second paragraph for each mental disorder specifies functional limitations (which vary according to the child's age) that must be present in one or more of four areas of functioning: motor, cognitive/communicative, social,

¹ The comment period on the proposal closed on October 13, 1989. The proposed revisions are largely patterned after the Part A mental impairment listing for adults (§ 12.00), which was revised in 1985, as required by Section 5(a) of the Social Security Disability Benefits Reform Act of 1984, (98 Stat. 1801). See Pet. App. 18a-20a; *City of New York*, 476 U.S. at 486 n.14.

and personal/behavioral. The proposed criteria also specify the requisite degree of departure from the developmental norm for each function. § 112.02B; App., *infra*, 18a-19a. In short, contrary to respondents' contention, there is no inconsistency between the Listing approach and recognition of functional considerations.

2. Nor is there any merit to respondents' contention that the regulations prevent an "individualized" determination of disability. As the Court explained in *Campbell*, 461 U.S. at 467, the Act's provision for individualized determinations based on evidence adduced at a hearing (42 U.S.C. 405(b)) "does not bar the Secretary from relying on rulemaking to resolve certain classes of issues." That is what the Secretary did in promulgating the Part B Listing. The Listing identifies qualifying criteria for particular impairments in children, and thereby also establishes both the general level of impairment severity that underlies the Listing and specific benchmarks against which unlisted impairments may be compared to determine whether they are of equivalent severity. A holding that the Secretary cannot prescribe such standards by rule "would require the agency continually to relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding." *Campbell*, 461 U.S. at 467. Within the framework of the Listing, the claimant is afforded a full opportunity to present medical and other evidence of the nature and extent of his impairment, his daily activities, and other relevant factors, in order to establish that his impairment is of sufficient severity to render him disabled. *Hinckley v. Secretary of HHS*, 742 F.2d 19, 23 (1st Cir. 1984); see *Campbell*, 461 U.S. at 467; *Yuckert*, 482 U.S. at 152-153.

3. Respondents, however, seek to require the Secretary to take functional considerations into account in a much different way. They contend that in every case in which the Secretary concludes that a child does not have an impairment that meets or equals the Listing, the Secretary must measure the child's "residual functional capacity" (RFC) and then determine whether that RFC—apparently when considered together with unspecified non-medical factors similar to an adult's age, education, and work experience—renders him disabled. See Resp. Br. 14, 16, 22, 23, 24 n.22, 30-32, 43-46.

The approach respondents propose would fundamentally change the focus and structure of the child's disability program

and would cut it loose from its moorings in the objective benchmarks of the Listing. Under the Listing approach, the claimant's eligibility turns on the severity of his impairment, as measured against the criteria in the Listing. By contrast, an RFC assessment does not measure the severity of the impairment itself; rather, it measures "what [the claimant] can still do *despite* [his] limitations" (20 C.F.R. 416.945 (emphasis added)). In other words, the Listing focuses on the extent to which a claimant's functional abilities are limited by his impairment, while RFC focuses on what abilities the claimant has left. Because Section 1382c(a)(3)(A) defines a child's disability in terms of whether his "impairment" is of a specified level of "severity" ("comparable"), it is entirely reasonable for the Secretary to make determinations of disability in children by reference to the Listing, which measures impairment severity, rather than RFC, which does not.²

Moreover, respondents lose sight of the fact that the RFC assessment of an adult is not a determination of whether he is disabled. See 20 C.F.R. 416.945(a), quoted at Gov't Br. 7 n.7. The RFC measurement merely aids the adjudicator in deciding whether a claimant whose impairment does not meet or equal the Listing nevertheless is disabled, because he cannot perform his previous work and also cannot (considering his age, education and work experience) engage in any other substantial gainful work in the national economy. In order to decide whether an adult can work despite his impairment, it is necessary to identify his residual capacity to do work-related activities (as well as any limitations resulting from advanced age or limited education and work experience). Thus, RFC is not part of the statutory eligibility standards even for adults; it is only an evaluative device developed by the Secretary for making the assessment, expressly required by Section 1382c(a)(3)(B), of the ability of an adult to work. Because Section 1382c(a)(3)(B) does not provide for an assessment of a child's ability to work or for an in-

² Viewed another way, the total functional capacity that the claimant would have if he were *not* impaired is the sum of: (1) the functional capacity he retains, and (2) the functional capacity he lacks because of his impairment (*i.e.*, the severity of his impairment). There is nothing in 42 U.S.C. 1382c(a)(3), or in the concept of "disability," that requires the Secretary to determine whether a child is disabled by reference to the former component (as respondents urge) rather than the latter (as governing regulations have long required).

dividualized consideration of any non-medical factors that are similar to an adult's age, education, and work experience, there is no occasion for the Secretary to consider a child's RFC.³

B. Despite the reasonableness of the Secretary's regulation establishing the Listing approach, respondents contend that the regulation conflicts with the Social Security Act and therefore is invalid on its face. Respondents and their amici do not seriously dispute our submission (Gov't Br. 19-23) regarding the applicable standard of review. See Resp. Br. 15; AMA Br. 10-11. Both the Listing itself and the regulation requiring a claimant for child's disability benefits to have an impairment that meets or equals the Listing were issued pursuant to the Secretary's "exceptionally broad authority" under 42 U.S.C. 405(a) to prescribe standards for giving content to the statutory definitions of disability. *Yuckert*, 482 U.S. at 145, quoting *Campbell*, 461 U.S. at 466. That general authority is augmented in this case by Section 501(b) of the Unemployment Compensation Amendments of 1976, which directed the Secretary to publish "criteria to be employed to determine disability" in children under 42 U.S.C. 1382c(a)(3). Part B of the Listing consists of the "criteria" that the Secretary published pursuant to that directive. Those criteria – and the corresponding regulation that requires a claimant's impairment to meet or equal the Listing – are entitled to "legislative effect" and are controlling on the courts unless they are "arbitrary, capricious, or manifestly contrary to the statute." *Atkins v. Rivera*, 477 U.S. 154, 162 (1986), quoting *Chevron U.S.A. Inc. v. NRDC, Inc.*, 467 U.S. 837, 844 (1984). At the very least, the regulatory requirement respondents challenge is not "manifestly contrary to the statute."⁴

³ As respondents point out (Br. 31), the regulations provide that RFC is a "medical assessment" (20 C.F.R. 416.945(a)) – although, like the medical assessment under the severity regulation and the Listing, it is based on functional considerations (*ibid.*). Contrary to respondents' assertion (Br. 5 n.6, 30-32), we do not argue otherwise in our opening brief. We simply point out (Gov't Br. 6-7, 26, 38) that RFC is measured only for purposes of determining an adult claimant's ability to work.

⁴ Respondents assert that the legal issue is a "pure question of statutory construction for the courts to decide" (Br. 15, quoting *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 (1987)) and that "[t]he judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear Congressional intent" (Br. 15). See also States' Br. 33-36. These assertions ignore the absence of any clear congress-

1. Section 1382c(a)(3)(A) provides that an individual "shall be considered to be disabled * * * if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment * * * (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity)." Respondents argue (Br. 17-19) that Congress's use of the word "comparable" prohibits exclusive reliance on the Listing and compels an assessment of RFC and non-medical factors, since the latter are considered in evaluating adults. The word "comparable," which is intrinsically imprecise, will not bear the weight respondents place on it. In fact, Section 1382c(a)(3) as a whole affirmatively supports the Secretary's approach in a number of respects.

a. Respondents err in stating that "Congress instructed the Secretary in 1972 to evaluate the severity of the impairments of children in a *manner* comparable to adults" (Br. 18 (emphasis added)). Section 1382c(a)(3)(A) does not require the Secretary to use "comparable methodology" in evaluating children;⁵ it states a *substantive* standard of "comparable severity" for impairments. Accordingly, the word "comparable" does not suggest that the Secretary must make an RFC assessment and consider non-medical factors for children simply because he does so for adults.

b. The initial clause of Section 1382c(a)(3)(A) focuses on the consequences of the impairment for an adult (whether he is unable to engage in any substantial gainful activity "by reason of" the impairment), which requires a determination of whether the claimant in fact *is* unable to work. This feature of the initial clause might suggest the need for an evaluative device such as RFC to measure the claimant's capacity for work (although the clause contains no express provision to that effect). But whatever the initial clause may require for adults, the parenthetical clause does not suggest that the Secretary must determine

sional intent to bar the Secretary's approach and the presence of the delegations of legislative rulemaking authority, under which "Congress entrust[ed] to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term." *Batterton v. Francis*, 432 U.S. 416, 425 (1977).

⁵ Compare 42 U.S.C. 1396a(a)(10) ("same methodology"), discussed in *Atkins v. Rivera*, 477 U.S. at 158; *Schweiker v. Hogan*, 457 U.S. 569, 573 n.6 (1982) ("comparable treatment").

whether a child in fact is unable to engage in any "substantial gainful" activity, and it therefore does not furnish a basis for inferring that the Secretary must employ an evaluative device such as RFC. The parenthetical clause instead focuses exclusively on the existence of a medically determinable impairment of a certain level of "severity." It is the Listing, not RFC, that addresses impairment severity. Thus, the text of Section 1382c(a)(3)(A) affirmatively supports the Secretary's Listing approach and substantially undermines respondents' position.

c. The term "severity" has consistently been used in the disability programs to refer to a *medical* assessment (albeit often one based on functional considerations, as under the Listing). *Yuckert*, 482 U.S. at 149 n.7; 42 U.S.C. 1382c(a)(3)(F) (Supp. V 1987). The presence of the term "severity" in the parenthetical clause of Section 1382c(a)(3)(A) therefore supports an evaluation based on medical factors alone, without considering vocational or other non-medical factors (and RFC), as in the case of an adult. This conclusion is reinforced by Section 1382c(a)(3)(B), which expressly provides for individualized consideration of non-medical factors (age, education, and work experience) for adults but omits any such reference to non-medical factors for children and omits any parenthetical "comparability" clause, such as that in paragraph (A), that might have served the same purpose. See *United States v. Erika, Inc.*, 456 U.S. 201, 208 (1982). The legislative history, moreover, confirms this reading of the text: The House Report describes the evaluation prescribed by Section 1382c(a)(3)(B) as applicable to individuals "other than a child under age 18" (H.R. Rep. No. 231, 92d Cong., 1st Sess. 148 (1971)).

d. Contrary to respondents' view (Br. 18-19), one of this Court's decisions upon which they rely makes clear that "[c]omparable * * * does *not* mean identical" (*Wheeler v. Barrera*, 417 U.S. 402, 420 (1974) (emphasis added)). For this reason, in establishing the general level of impairment severity that will lead to a finding of disability and identifying particular impairments that attain that level, the children's Listing need not correspond precisely to the level of severity that is generally applicable to adults or include every impairment that would lead the Secretary to find some or all adults disabled.

e. The foregoing conclusion is supported by the operation of the sequential evaluation process that has been implemented

for adults under Section 1382c(a)(3)(A) and (B). It is true that an adult whose impairment does not meet or equal the Part A Listing at step three of that process may be found disabled at step five—if, in light of his age, education and work experience, he is unable to perform any substantial gainful work that exists in the national economy. But in that event, the basis of the disability finding is not the “severity” of his impairment standing alone, but rather the severity of the impairment *plus* an adverse vocational factor, such as advanced age, a relative lack of education, or limited work experience.⁶ The claimant’s impairment therefore is *not* one that would lead adults to be found disabled as a general matter, since all adults who did not also have one or more adverse vocational factors would be denied benefits. Accordingly, contrary to respondents’ contention (Br. 19), if the same non-listed impairment was present in a child, it would *not* be one of “comparable severity” to an impairment that necessarily would render an adult disabled. A finding that a child having such an impairment is not disabled therefore is entirely consistent with the text of Section 1382c(a)(3)(A).⁷

⁶ See SSR 86-8, West Soc. Sec. Rept. Serv. (Rulings) 510 (Supp. 1989) (“Under the regulations, a finding that an individual’s impairment(s) does not meet or equal the Listing effectively indicates that he or she has a sufficient work capability at the sedentary or a higher exertional level, to require medical-vocational evaluation.”); 43 Fed. Reg. 55,353 (1978) (“If . . . an individual does not have the physical-mental capacity to perform work even at a sedentary level[,] . . . the individual should ordinarily have been determined to be disabled based solely on consideration of the medical severity of impairment under [the Listing]”).

⁷ Experience has shown over the past 14 years that in the substantial majority (usually more than 75%) of cases in which adults have been found to be disabled, the claimant met or equaled the Listing. See House Comm. on Ways & Means, 101st Cong., 1st Sess., *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, 46 (Table 2) (Comm. Print 1989), reproduced at Nat. Org. of Soc. Sec. Cmmts’ Reps. Br. A2. This experience further corroborates that the “comparable severity” standard is satisfied under the Secretary’s approach, because it shows that the substantial majority of adult claimants have impairments of a level of severity that is comparable to the level embodied in the Part B Listing for children.

Respondents are correct that the “guides” (now the Listing) were not originally developed in the 1950s to be a dispositive basis for disability determinations, since vocational factors were to be taken into account for the wage-earner claimants then covered by the Title II program. See Br. 21-22, 24. But from the outset, it was intended that the “great majority” of claims would be determined on the basis of medical factors alone, including through use of the

2. Respondents argue (Br. 26-36) that the Listing requirement in the regulations is not entitled to deference because it was not contemporaneously adopted by the Secretary and has not been consistently maintained. This argument is conclusively refuted by the history of the regulations.

a. The SSI program went into effect on January 1, 1974. Gov’t Br. 2 n.1. On January 11, 1974, the Secretary published proposed regulations governing determinations of disability under the SSI program. 39 Fed. Reg. 1624 (1974). The regulation relevant here stated that “[d]isability shall be deemed to exist for a child under age 18” if: (1) the child is not engaging in substantial gainful activity, (2) his impairments satisfy durational requirements, and (3) his impairments “are listed in the appendix” or, if not listed, are determined by SSA, “with appropriate consideration of the particular effect of disease processes in children,” to be “medically the equivalent of a listed impairment.” *Id.* at 1626, adding 20 C.F.R. 416.904; see also 40 Fed. Reg. 31,778, 31,783 (1975) (final regulation). Thus, the regulatory requirement respondents challenge was instituted at the very outset of the SSI program.

That requirement has been reaffirmed and consistently maintained ever since. In March 1977, after Congress directed the Secretary to publish “criteria” for determining disability in children, the Secretary published a revision of 20 C.F.R. 416.904, which again stated that a child under age 18 must meet or equal the Listing, including a new Part B of the Listing, which contained the statutorily mandated “criteria” for making determinations under 416.904. 42 Fed. Reg. 14,705 (1977). And when the Secretary thoroughly revised the disability regulations in 1980, he again retained the Listing requirement for children (45 Fed. Reg. 55,625, adding 20 C.F.R. 416.923), specifically rejecting the contention, now advanced by respondents, that it is inconsistent with the “comparable severity” language in Section

guides. SSA, *Disability Freeze State Manual* § 304.B (1955) (copy lodged with the Clerk); see also *Administration of Social Security Disability Insurance Program: Hearings Before the Subcomm. on the Administration of the Social Security Laws of the House Comm. on Ways and Means*, 86th Cong., 1st Sess. 342-343 (1959) (90% of allowances based on meeting or equaling the listing). Nothing in the early experience suggests that the Listing is an inappropriate basis for disability determinations where, as here, vocational factors are not considered and disability is based on medical factors alone.

1382c(a)(3)(A). 45 Fed. Reg. 55,570-55,571 (1980). The regulation has remained in effect ever since. See 20 C.F.R. 416.924 (1988).

b. Respondents attempt to negate the contemporaneous and longstanding interpretation embodied in the Secretary's published regulations by asserting (Br. 27-32) that SSA took a different position in Disability Insurance Letter (DIL) No. III-11 (J.A. 89-93) and the Supplement thereto (J.A. 94-114), which were transmitted to the state agencies on September 7, 1973, and January 9, 1974, respectively. This assertion is equally baseless. DIL III-11 explicitly stated that "childhood disability will be determined solely in consideration of medical factors" and that "[v]ocational factors *will not* be considered" (J.A. 91). The Supplement was transmitted contemporaneously with the publication of the SSI disability regulations in January 1974, and it stated that the regulations "specifically require[] that a child's impairment or impairments must either *meet* or *equal* the listing of impairments" (J.A. 95). The remainder of the Supplement was devoted to explaining how the adult Listing would be applied to children, how a separate set of criteria for children would be developed out of informal guides, how the equivalence concept operated, and how evidence of the impairment's impact, the child's school activities, developmental milestones, and other factors could be taken into account in determining whether a child's impairment satisfied the level of severity in the Listing (J.A. 95-100). Although these two transmittals obviously support our position that the special criteria for children have been firmly rooted in functional considerations from the outset, neither contains the slightest support for respondents' assertion (Br. 28, 30-31, 35, 41-42) that the Secretary was contemplating something other than a requirement that a child's impairment must meet or equal the Listing.

3. Respondents also take issue (Br. 37-42) with our submission (Gov't Br. 32-33) that the Listing requirement derives still further support from Section 501(b) of the Unemployment Compensation Amendments of 1976. However, they entirely ignore the explicit text of that statute. Section 501(b) directed the Secretary to "publish criteria to be employed to determine disability (as defined in [42 U.S.C. 1382c(a)(3)]) in the case of persons who have not attained the age of 18." The term "criteria" connotes specific "standard[s]" on which a decision or

judgment may be based"—"yardstick[s]" against which the severity of impairments may be measured. *Webster's Third New International Dictionary* 538 (1976) ("criterion"). It thus aptly describes the detailed standards in the Listing of Impairments, and indeed the introduction to both Part A and Part B of the Listing uses the term "criteria" to describe those standards (J.A. 115, 206). Furthermore, Section 501(b) states that the criteria in the Listing are to "determine" the question of disability in children. The text of Section 501(b) therefore refutes respondents' position (Br. 19 n.17) that the Secretary may not use the Listing as anything more than a screening device, and that the criteria in the Listing may never be the "sole determinant" of disability.

The legislative history of Section 501(b) confirms this interpretation and shows that Congress fully understood that the published "criteria" would *implement* the Listing approach, not depart from it, as respondents contend (Br. 40-41). The Senate Report, quoting the regulation published by the Secretary in January 1974, specifically noted that "[t]he regulations that have been issued with regard to disability for children state that if a child's impairments are not those listed," the child may still be found eligible if his impairments are found "to be medically the equivalent of a listed impairment." S. Rep. No. 1265, 94th Cong., 2d Sess. 24 (1976). The Report further noted that the Secretary had for some time been circulating draft regulations "with criteria for child disability," but that they had "not yet been issued." *Id.* at 25. The purpose of Section 501(b) was to dislodge those criteria from SSA. Respondents' contrary notion—that the Senate Committee expected the Secretary to abandon the Listing-only approach—cannot be squared with Section 501(b)'s allowance of only 120 days for the Secretary to complete the task, a period that would have been insufficient to design an entirely new regulatory approach, as respondents now urge.

The Senate Report also underscores the congressional purpose to require the Secretary to develop "objective criteria" (*id.* at 25) and "more definitive guidelines" to replace the "statements" and "temporary guidelines" that SSA had previously furnished to the States in DIL III-11 and its Supplement in 1973 and 1974 (*id.* at 24). In the Committee's view, publication of the

criteria would "end the present uncertainty which the State agencies and others have with regard to what constitutes disability in a child" and provide an "equitable basis" for administering the program. *Id.* at 25; accord 122 Cong. Rec. 33,301 (1976) (Sen. Long); *id.* at 33,302 (Sen. Bayh). The amorphous RFC approach respondents urge would conflict with those goals.

Respondents attempt to blunt the force of the Senate Report by relying (Br. 38) on excerpts from a floor statement by Representative Mikva concerning a bill that would have directed the Secretary to promulgate "criteria (including medical, social, personal, educational, and other criteria) for the determination of disability" in children. H.R. 8911, 94th Cong., 2d Sess. § 4(e) (1976); 122 Cong. Rec. 27,883 (1976). Significantly, however, the reference to "medical, social, personal, educational and other criteria" was omitted from Section 501(b) as finally enacted. In any event, Representative Mikva's remarks in fact support the Secretary's Listing approach. He described the bill as requiring "specific and standardized disability criteria for children" (122 Cong. Rec. 27,855 (1976)), which is exactly what the Listing consists of. His further statement that those criteria should "take into account not only the medical development of the child but also the child's social, educational, and personal development" (*ibid.*) is fully consistent with the Listing approach as well. The general level of impairment severity in Part B takes into account the impact of impairments on a child's growth and development, and the proposed revision of the mental impairment listing provides for an even more particularized assessment in this regard.⁹

C. In addition to challenging the Listing requirement, respondents and their amici criticize certain aspects of the Listing itself, the manner in which it has been applied to particular diseases or even particular claimants, and certain other features of the disability determination process. These criticisms

⁹ The post-debate statement of Senator Hathaway, upon which respondents also rely (Br. 39), likewise is fully consistent with the Secretary's Listing approach. Indeed, the Senator acknowledged that "[m]edical criteria used in the broad sense of the total health development of the child could indeed provide the basis for determining the comparable severity of a child's impairment." 122 Cong. Rec. 34026 (1976).

are largely unfocused and unrelated to the single but significant legal issue in this case concerning a facial challenge to the Listing requirement.⁹ As the district court observed, "[i]f these [Listing] criteria are being misapplied or misinterpreted, the remedy lies in the appeal process in individual cases, not in a class-action decree" (Pet. App. 24a).¹⁰ Similarly, if any of the

⁹ For example, respondents speculate (Br. 20, 24 & n.22, 32) that a child's multiple impairments might not be adequately evaluated. However, 42 U.S.C. 1382c(a)(3)(F) (Supp. V 1987), specifically requires that the combined effect of multiple impairments be considered in every case (*Yuckert*, 482 U.S. at 149-152), and that requirement is implemented by regulations (20 C.F.R. 416.923, 416.926(a)) and SSR 83-19 (J.A. 239). Similarly, although respondents speculate about how allegations of pain are considered, they acknowledge that there are statutory and regulatory provisions governing that issue as well. Br. 24 n.22, 31-32; see 42 U.S.C. 1382c(a)(3)(G) (Supp. V 1987); SSR 88-13, West Soc. Sec. Rept. Serv. (Rulings) 737-738 (Supp. 1989). Several sections of the Listing identify pain as a relevant factor (§§ 1.00A&B, 4.00D&E, 101.00A (J.A. 116-117, 141-142, 208)), and pain may be taken into account where it results in functional limitations. Any issues concerning the application of these standards must await individual cases in which those issues are actually presented.

¹⁰ Respondents argue (Br. 24-25, 32-33) that application of the concept of equivalency to a listed impairment might not sufficiently take into account functional consequences of the unlisted impairment. They first criticize (Br. 32-33) the Secretary for what they view as a departure from the Supplement to DIL III-11 in 1974, which urged reliance on equivalence to decide difficult cases. See J.A. 97. However, that advice was given before SSA had fully developed separate Listing criteria specifically for children's impairments, and it therefore was necessary to compare such impairments to the adult criteria. The issuance of the detailed children's criteria in 1977 has diminished the need for reliance on the equivalency concept.

Respondents also object (Br. 24, 32-33) that SSR 83-19 unduly limits consideration of the functional impact of an unlisted impairment in deciding whether it equals a listed impairment. The passages on which they rely for this assertion state that equivalency cannot be based on an assessment of "overall functional impairment" (J.A. 239) or RFC (J.A. 240). These passages merely reiterate that the Listing approach focuses not on RFC or the claimant's overall capacity *despite* his impairment, but rather on the severity of the impairment itself. Contrary to respondents' view, SSR 83-19 was not intended to bar consideration of the functional impact of an unlisted impairment in deciding whether it is equal in severity to a listed impairment. We have been informed by HHS that consideration is being given to a possible clarification of SSR 83-19 on this point.

Respondents assert (Br. 32 n.29) that the number of equivalency findings began to "drop precipitously" after SSR 83-19 was issued. In fact, the Committee Print upon which they rely (see note 7, *supra*) shows that the decline

amicus groups believe that the Listing does not adequately address certain types of impairments or should be updated, they may petition the Secretary to initiate a rulemaking proceeding to revise particular criteria or may participate in on-going proceedings for that purpose.¹¹

These scattershot criticisms should not, however, be permitted to obscure the significant conceptual, policy and pragmatic difficulties with the RFC approach respondents propose in this case. Most critically, respondents do not offer any meaningful articulation of an appropriate benchmark, similar to an adult's ability to work, against which decision-makers would measure a child's RFC; nor do they describe the manner in which a disability determination would be made on the basis of a child's RFC. The most basic question of course is: residual functional capacity to do what? Amici AMA, et al., concede "that for children there is no single benchmark for conducting a functional analysis like employment for adults" (Br. 21). Respondents suggest in passing (Br. 45) that the RFC assessment might measure the child's residual capacity to engage in "age-appropriate activities."¹² But would eligibility depend on an

began well before SSR 83-19 was issued, and it corresponded with an increase in the number of findings that an impairment met the Listing. This development reflects the evolution of the criteria in the Listing as a reliable measure of impairment severity. A study of the child's disability program upon which respondents otherwise rely concludes that children with single diseases that are not included in the Listing are not unduly hindered in establishing eligibility. Fox & Gearney, *Disabled Children's Access to SSI and Medicaid Benefits* 47-51 (1988). Although respondents point out (Br. 23) that this study was "funded by the Secretary," they fail to point out that it was released with a disclaimer (a copy of which is lodged with the Clerk) because its data were not regarded as statistically valid.

¹¹ The fact that the Listing might not mention a particular disease or condition by name does not in itself suggest a gap in the Listing, as respondents and amici intimate. The manifestations of that disease or condition may nonetheless be found to meet or equal the Listing. For example, we have been informed by SSA that the vast majority of children with Down Syndrome are found to be disabled, even though that Syndrome is not yet included, as such, in the Listing. See note 16, *infra*.

¹² Respondents erroneously argue (Br. 45) that the Secretary has endorsed an "age-appropriate activities" approach for children in the regulations implementing the medical improvement standard in 42 U.S.C. 1382c(a)(5) (Supp. V 1987). Under those regulations, medical improvement is deemed to

inability to engage in *any* age-appropriate activities, just as Section 1382c(a)(3)(A) requires an adult to show that he cannot engage in "*any* substantial gainful activity"? If an inability to perform only *some* age-appropriate activities would suffice, which ones would they be? How far below the norm would the claimant's residual capacity have to fall, and would his deficiency be measured in the aggregate or for each age-appropriate activity? What non-medical factors (similar to an adult's age, education and work experience) would be considered together with the child's RFC: His education? Social experience? Family background? Intellectual and emotional development? And would normal or above-normal ratings for some non-medical factors offset adverse aspects of others?

In addition, because physical, mental and emotional development varies widely even among unimpaired children, it might often be difficult for an adjudicator to determine how much of a child's deficit in a particular area is attributable to an impairment and how much is within an acceptably "normal" range. It might also be difficult to measure or quantify a child's *overall* residual functional capacity, especially in young children. Because of these difficulties, decisions concerning each claimant's overall ability to engage in age-appropriate activities (in light of his RFC and whatever non-medical factors were deemed

have occurred in a child (which then permits the Secretary to evaluate the claimant under generally applicable standards) "if there has been any medical improvement in [the claimant's] impairment(s)" and if "this medical improvement is related to [the claimant's] ability to work (i.e., [his] ability to perform age-appropriate activities)." 20 C.F.R. 416.994(c) and (1)(ii). These regulations merely identify in general terms the minimal nexus that must be found as a threshold matter between the improvement in the child's medical condition and his relevant functional abilities. If this nexus is present, the test of disability is not whether the child can perform "age-appropriate activities," but whether his impairment meets or equals the Listing. See 20 C.F.R. 416.994(c).

Respondents also err in relying (Br. 44-45) on the Title II provision for payment of insurance benefits to a wage-earner's adult child who became disabled before age 22. That provision expressly requires the child to satisfy the standard of disability for adults under 42 U.S.C. 423(d) (see 42 U.S.C. 402(d)(1)(B) and (G)), and therefore requires a showing that the claimant cannot perform any substantial gainful activity. It is for this reason that such claimants are evaluated under the five-step sequential evaluation process for adults. The RFC assessment in such a case of course focuses on the claimant's capacity to perform *work* activities, not "age-appropriate activities."

relevant) might be unduly subjective and ad hoc, thereby undermining the statutory goal of uniformity among the thousands of adjudicators in the state agencies and SSA. See 42 U.S.C. 421(a)(2); *Heckler v. Day*, 467 U.S. 104, 116 (1984).

Respondents and their amici do not offer any answers to these and other questions raised by the RFC approach they urge. Moreover, there can be no claim that Congress has supplied any of these answers. See AMA Br. 14 ("Congress did not set out specific functions that children perform that could be compared directly to ability to work for adults."). At bottom, what respondents seek is a judicial restructuring of the child's disability program based on ill-defined notions that Congress has not adopted. Whatever the merits of their proposal, it is addressed to the wrong forum. There simply is no warrant for the courts to undertake the task of redesigning the child's disability program from the bottom up under the guise of interpreting the ambiguous words "comparable severity."

D. We do not suggest that the child's disability program is free of any difficulties or errors. It is a program of substantial dimensions that must respond to genuine needs, rapid medical and technological advances, and the imperatives of equitable, efficient and uniform adjudication. Its administration therefore requires difficult and expert judgments concerning public and statutory policy and sound administration. Congress has vested responsibility for those matters in the Secretary in the first instance, subject to plenary legislative oversight but only limited judicial review.

Congress in fact is now considering proposals for formal studies and possible revisions of the child's disability program. The budget reconciliation bill passed by the House of Representatives on October 5, 1989, would amend the Act, effective October 1, 1989, to provide the first express statutory directive for an "individualized assessment" of a child's impairments "that prevent or significantly interfere with the activities of daily living appropriate to the age of the child." H.R. 3299, 101st Cong., 1st Sess. § 10,222 (1989) (135 Cong. Rec. H6131 (daily ed. Sept. 27, 1989)); see House Comm. on Ways & Means, 101st Cong., 1st Sess., *Summary of Budget Reconciliation Provisions Under The Jurisdiction of the Committee on Ways and Means*

31-32 (Comm. Print 1989).¹³ The Senate Finance Committee's recommendations for the bill instead would provide for a 15-member Commission to study the definition of disability in children, whether an individualized functional assessment would be appropriate (and what criteria might be employed), and how Part B of the Listing should be revised. 135 Cong. Rec. S13,205 (daily ed. Oct. 12, 1989).¹⁴ The Secretary also has conducted an internal study of children's claims,¹⁵ has instituted revisions of the Part B Listing,¹⁶ and is considering various other measures, including the broader use of pediatricians in evaluating claims and more intensive review by SSA of state-agency adjudications. *Preliminary Report*, Tab F. Especially in view of this intensive scrutiny and possible revisions of the child's disability program by both the Secretary and Congress,

¹³ The House bill also would establish a rule of presumptive disability for certain children under age 4 with genetic or congenital impairments, including cystic fibrosis, Down's syndrome, Tourette syndrome, Prader Will syndrome, and spina bifida (§ 10,223), and require that the mental impairment and other children's listings be revised (§§ 10,224, 10,225).

¹⁴ The Committee's recommendations also would provide for the commission to study the validity of the presumption of disability proposed by the House bill for certain young children (see note 13, *supra*), require pediatricians to participate in disability determinations, and mandate review by SSA of 50% of all state-agency denials of child's disability claims. 135 Cong. Rec. S13,205-S13,206 (daily ed. Oct. 12, 1989).

¹⁵ See SSA, Office of Disability, *Preliminary Staff Report: Childhood Disability Study*, Tab E, at 1 (Sept. 20, 1989) (copy lodged with the Clerk). The study revealed a high error rate for several categories of impairments: growth impairments (42%), cardiovascular (29%), and digestive (13%). *Id.*, Tab D, at Table 3. The results of this study led to the Finance Committee's recommendation that SSA review 50% of all state agency denials. 135 Cong. Rec. S13,205 (daily ed. Oct. 12, 1989).

¹⁶ Because approximately 60% of child's disability claims involve allegations of mental impairments (*Preliminary Report*, Tab E, at 1), the final revision of the mental impairment listings will have a broad impact. New listings for Down Syndrome and other Hereditary, Congenital and Acquired Disorders, which were proposed in October 1987 (52 Fed. Reg. 37,161), are scheduled for final publication in February 1990. *Preliminary Report*, Tab F, at 1. Proposed revisions in the children's musculoskeletal and cardiovascular listings are in the latter stages of administrative review prior to publication of a notice of proposed rulemaking. *Ibid.*

the Court should reject respondents' request for a judicial restructuring of the way in which that program has been administered since 1974.

For the foregoing reasons and those stated in our opening brief, it is respectfully submitted that the judgment of the court of appeals should be reversed.

KENNETH W. STARR
Solicitor General

OCTOBER 1989

APPENDIX

NOTICE OF PROPOSED RULEMAKING

54 Fed. Reg. 33,238 (Aug. 14, 1989)

Proposed Revision of Medical Criteria for Evaluating
Mental Disorders of Children Under Age 18.

* * * * *

The proposed revisions serve several purposes. The medical terms used to describe the major mental disorders of childhood and their characteristics and symptoms have been updated to conform to the nomenclature currently used widely by psychiatrists, psychologists, and other mental health professions. Terminology in the listings is based on that used in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III) published by the American Psychiatric Association (APA) in 1980. This edition gives a common basis for communication, which is particularly important in evaluating medical reports used in determining disability. The DSM III-Revised, which was published in May 1987 and after these evaluation criteria were developed, does not differ in its applicable terminology.

The proposed listings are also more specifically related to distinct types of mental disorders. Thus, fewer disorders are included under the same listing than are grouped together under the current listings. The result is an increase in the number of listings from four to nine. In the proposed listings, the organization of mental disorders is based on the DSM III which provides a realistic organization in terms of the common characteristics of the mental disorders that are evaluated under a particular listing. The more recently published DSM III-Revised does not differ in its organization.

Since the body of knowledge on the characteristics, treatment and management of mental disorders in children

(1a)

is constantly evolving, the Social Security Administration (SSA) will provide for the ongoing evaluation of the medical criteria for evaluating mental disorders in children to ensure that the criteria reflect the most up-to-date knowledge on those disorders.

* * * * *

The following is a summary of the proposed listings.

112.00 Preface

We are proposing several significant additions to the preface to the mental disorders listings for children under age 18. Proposed Introduction, 112.00A of the preface explains the basic approach used in the listings that follow. It explains that most of the listings use a new dual approach which divides each listing into two paragraphs: the first paragraph (the A paragraph) describes the characteristics necessary to substantiate the existence of the mental disorder, while the second paragraph (the B paragraph) describes the applicable restrictions and functional limitations which result from the disorder in children.

In 112.00B of the preface, Need for Medical Evidence, we describe the need for medical evidence to substantial [sic] the existence of a medically determinable impairment.

In 112.00C of the preface, Assessment of Severity, we describe in detail the multiple factors in the paragraph B criteria of most listings which pertain to functional limitations and restrictions in various age groups in children. This significant revision in the mental disorders listings has been introduced because mental health professionals consider such factors particularly important in evaluating mental disorders of children. It should be noted that although the items in paragraph B are identical for most listings, the number of items required varies for particular listings.

In 112.00D of the preface, Documentation, we discuss the evidence needed to document mental disorders in children.

In 112.00E, Effect of Hospitalization of Residential Placement, and 112.00F, Effects of Medication, we also include new information relating to mental disorders in children. This material explains that evaluation of mental disorders must include consideration of the fact that medications, hospitalizations, or other highly structured living arrangements may minimize the overt indications of severe chronic mental disorders without necessarily affecting the functional limitations imposed by the disorder. The proposed 112.00F also acknowledges that medications may sometimes produce side effects that add to the functional limitations resulting from mental disorders in children.

* * * * *

For the reasons set out in the preamble, Part 404, Subpart P, and Part 416, Subpart I, of Chapter III of Title 20, Code of Federation Regulations is amended as set forth below.

* * * * *

4. Part B of Appendix 1 (Listing of Impairments) of Subpart P is amended by revising 112.00, Mental and Emotional Disorders, to read as follows:

112.00 Mental Disorders

A. *Introduction:* The structure of the mental disorders listing for children under age 18 parallels the structure for the mental disorders listings for adults but is modified to reflect the presentation of mental disorders in children. The listings for mental disorders in children are arranged in 9 diagnostic categories: Organic mental disorders (112.02); psychotic

disorders (112.03); affective disorders (112.04); mental retardation (112.05); anxiety-related disorders (112.06); disorders with physical manifestation (112.07); personality disorders (112.08); autism and other pervasive developmental disorders (112.09); and developmental and emotional disorders of infancy (112.10).

There are significant differences between the listings for adults and the listings for children. There are disorders found in children that have no real analogy in adults, hence the differences in the diagnostic categories for children. The presentation of mental disorders in children, particularly the very young child, may be subtle and of a character different from the signs and symptoms found in adults. For example, a finding such as an infant's failure to mold or bond with the parent(s) has grave prognostic implications and serves as a finding comparable in severity to the findings that mark mental disorders in adults.

The activities appropriate to children such as learning, growing, playing, maturing, and school adjustment are also different from the activities appropriate to the adult and vary widely in the different childhood stages.

Each listing begins with an introductory statement that describes the syndrome or syndromes addressed by the listing. This is followed (except in listings 112.05, 112.08 and 112.10) by clinical findings (paragraph A criteria), which, if satisfied, lead to an assessment of functional limitations (paragraph B criteria). An individual will be found to have a listed impairment when the criteria of both paragraphs A and B of the listed impairment are satisfied.

The purpose of the criteria in paragraph A is to substantiate medically the presence of a particular

mental disorder. Specific signs and symptoms under any of the listings 112.02 through 112.10 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) indicated by the clinical findings.

Paragraph A of the listings is a composite of clinical findings which are used to substantiate the existence of a disorder and may or may not be appropriate for children at specific developmental stages. However, a range of clinical findings is included in the listings so that no age group is excluded. For example, in listing 112.02A7, emotional lability and crying would be inappropriate criteria to apply to infants and young children; whereas in 112.02A1, developmental arrest, delay or regression, are appropriate criteria for infants and young children. Whenever the adjudicator decides that the requirements of paragraph A of a particular mental listing are satisfied, then that listing should be applied regardless of the age of the child to be evaluated.

The purpose of the paragraph B criteria is to describe functional limitations which are applicable to children. Standardized tests of social or cognitive function and adaptive behavior are frequently available and appropriate for the evaluation of children and, thus, such tests are included in the paragraph B functional parameters. The functional restrictions in paragraph B must be the result of the mental disorder which is manifested by the clinical findings in paragraph A.

We have not included separate C criteria for listings 112.03 and 112.06 as are found in the adult listings because, for the most part, we do not believe that

categories like residual schizophrenia or agoraphobia are commonly found in children. However, in individual cases where these disorders are found in children and are comparable to the severity and duration found in adults, the adult 12.03C and 12.06C criteria may be used for evaluation of the cases.

The structure of the listings for Mental Retardation (112.05), Personality Disorders (112.08) and Developmental and Emotional Disorders of Infancy (112.10) is different from that of the other mental disorders. Listing 112.05 (Mental Retardation) contains four criteria, any one of which, if satisfied, will result in a finding that the child's impairment meets the listing. Listing 112.08 (Personality Disorders) is a reference listing referring the evaluator to listing 12.08 of the adult listings. Listing 112.10 (Developmental and Emotional Disorders of Infancy) contains four criteria, any one of which, if satisfied, will result in a finding that the infant's impairment meets the listing.

Need for Medical Evidence: The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of signs, symptoms and/or laboratory, psychological or developmental test findings. Psychiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation, development and contact with reality as described by an appropriate medical source. Symptoms are complaints presented by the child. Signs and symptoms generally cluster together to constitute recognizable clinical syndromes (mental disorders) described in paragraph A of the listings. These findings may be intermittent or continuous depending on the nature of the disorder.

C. Assessment of Severity: In childhood cases, as with adults, severity is measured according to the functional limitations imposed by the medically determinable mental impairment. However, the range of functions used to assess impairment severity for children varies at different stages of maturation. The criteria address age-appropriate functional limitations for each age group in some or all of the following areas: motor function, cognitive/communicative function, social function and personal/behavioral function. In most functional areas two separate methods of documenting the required level of severity are: use of standardized tests (where appropriate test instruments are available) and use of clinical findings. The use of standardized tests is the preferred method of documentation if such tests are available.

Newborn and young infants (birth to attainment of age 1) have not developed sufficient personality differentiation to permit formulation of appropriate diagnoses. We have, therefore, assigned listing 112.10 for Developmental and Emotional Disorders of Infancy for the evaluation of mental disorders of such children. Severity of these disorders is based on measures of development in motor, cognitive/communicative and social functions.

In defining the severity of functional limitations, two different sets of paragraph B criteria corresponding to two separate age groupings have been established, in addition to the individual infant listing 112.10. These age groupings are: infants and toddlers (age 1 to attainment of age 3) and children (age 3 to attainment of age 18). However, the following discussion on the age-appropriate areas of function is broken down into four age groupings, i.e., infants and toddlers (age 1 to attainment of age 3), preschool

children (age 3 to attainment of age 6), primary school children (age 6 to attainment of age 12) and adolescents (age 12 to attainment of age 18). This was done to better explain the age group variances in disease manifestations and methods of evaluation.

1. *Infants and toddlers (age 1 to attainment of age 3).* In this age group, impairment severity is assessed in three areas: motor development, cognitive/communicative function, and social function. In infancy, much of what we can discern about mental function comes from observation of the degree of fine and gross motor function. Developmental delay as measured by a good developmental milestone history confirmed by medical examination is critical. If the delay is such that the infant or toddler has not achieved motor development generally acquired by children no more than one-half the child's chronological age, the criteria are satisfied.

Cognitive/communicative function is measured using one of several standardized infant scales. Appropriate tests for the measure of such function are discussed in 112.00D; care should be taken to avoid reliance on screening devices, which are not considered to be sufficiently reliable instruments, although such devices may provide some relevant data.

For infants and toddlers, alternative criteria covering disruption in communication as measured by their capacity to use simple verbal and nonverbal structures to communicate basic needs is provided.

Social function in infants and toddlers is measured in terms of the development of relatedness (i.e., bonding, stranger anxiety, etc.) and attachment to animate or inanimate objects. Criteria are provided that use standard social maturity scales or alternative

criteria that describe marked impairment in socialization in terms of separation anxiety, withdrawal and failure to develop appropriate response to external stimuli.

2. *Preschool children (age 3 to attainment of age 6).* For the age groups including preschool children through adolescents, the functional areas used to measure severity are: cognitive/communicative function, social function, and personal/behavioral function. After 36 months, motor function is no longer felt to be a primary determinant of mental function, although, of course, any motor abnormalities should be documented and evaluated. In the preschool years and beyond, cognitive function can be measured by standardized tests of intelligence although the appropriate instrument may vary with age. A primary criterion for limited cognitive function is a valid verbal, performance, or full scale I.Q. of 69 or less. The listings also provide alternative criteria consisting of tests of language development of bizarre speech patterns.

Social function is measured by relationships with parents, other adults, and peers.

Personal/behavioral function may be measured by a standardized test of adaptive behavior or by careful description of serious maladaptive or avoidant behaviors.

3. *Primary school children (age 6 to attainment of age 12).* The measures of function here are similar to those for preschool-age children except that the test instruments may change and the capacity to function in the school setting supplements information in the cognitive and social parameters. Scores which are at least two standard deviations below the age-appropriate norm on standardized measures of academic

achievement represent a marked impairment in function. As described in 112.00D, Documentation, school records are an excellent source of information concerning function and standardized testing and should always be sought for school-age children.

4. *Adolescents (age 12 to attainment of age 18).* Functional criteria parallel to those for primary school children are provided for this age group. It should be remembered, however, that mental disorders in adolescence may more closely resemble those of adults than children. Therefore, if, based on the description of the disorder by the clinician, the adjudicator believes the medical criteria of Part B do not apply, the adult listing criteria will be used.

Again, the same three general areas of function as in the primary school group (cognitive/communicative, social, and personal/behavioral) are measures of severity for this age group. Testing instruments appropriate to adolescents should be used. Comparable clinical findings of disruption of social function must consider the capacity to form appropriate, stable and lasting relationships. If information is available about cooperative working relationships in school or at part or full-time work, or about the ability to work as a member of a group, it should be considered when assessing the child's social and/or personal/behavioral functioning. Markedly impoverished social contact, isolation, withdrawal, or inappropriate or bizarre behavior under the stress of socializing with others also constitutes comparable clinical findings.

The intent of the functional criterion described in paragraph B2d common to the listings, i.e., deficiencies of concentration, persistence or pace resulting in failure to complete work-like tasks in a timely manner is to identify the school-age child age 6 to attainment

of age 18 who cannot adequately function in school because of a mental impairment. Although grades and the need for special education placement are relevant factors which must be considered in reaching a decision under paragraph B2d, they are not conclusive. There is too much variability from school district to school district in the expected level of grading and in the criteria for special education placement to justify reliance solely on these factors.

Where "marked" is used as a standard measuring the degree of limitation, except as defined in 112.00C3, it means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with the ability to function independently, appropriately, and effectively. When standardized tests are used as the measure functional parameters, a valid score that is two standard deviations below the norm for the test will be considered a marked restriction.

D. *Documentation:* The presence of a mental disorder in a child must be documented on the basis of reports from acceptable sources of medical information. See §§ 404.1513 and 416.913. Description of functional limitations may be available from these sources and may be supplemented by reports from parents or other concerned adults who are aware of the child's activities of daily living, social functioning, and ability to adapt to different settings and expectations.

For very young infants, it may be very difficult to document the presence or severity of a mental disorder. Therefore, with the exception of some genetic diseases and catastrophic congenital

anomalies, it may be necessary that some cases be held until the child attains 3 months of age in order to obtain adequate observation of behavior or emotional affect. This period would be extended in cases of premature infants proportionately to the degree of prematurity.

For very young infants and toddlers, programs of early intervention involving occupational, physical and speech therapists, nurses, social workers, and special educators, are a rich source of data. They can provide the developmental milestone evaluations as records on the fine and gross motor functioning of an infant. This information is valuable and can complement the medical examination by a physician. The report of interdisciplinary team which contains the evaluation and signature of an acceptable medical source can be considered acceptable medical evidence rather than supplemental data.

In children with mental disorders, particularly those requiring special placement, school records are a rich source of data, and the required reevaluations at specified time periods can provide the longitudinal data needed to trace impairment progression over time.

In some cases where the treating source(s) lack expertise in dealing with mental disorders of children, it may be necessary to obtain evidence from a psychiatrist or psychologist with experience and skill in the diagnosis and treatment of mental disorders as they appear in children. In these cases, however, every effort should be made to obtain the records of treating sources, since these records will help establish a longitudinal picture that cannot be established through a single purchased examination.

For purposes of these childhood mental disorders listings, standardized psychological testing indicates the use of a psychological test that has appropriate characteristics of validity, reliability, and norms, administered individually by a psychologist or psychiatrist qualified by training and experience to perform such an evaluation. Psychological tests are best considered as a set of tasks or questions designed to elicit particular behaviors when presented in a standardized manner.

The salient characteristics of a good test are: 1) validity, i.e., the test measures what it is supposed to measure, as determined by appropriate methods; 2) reliability, i.e., the consistency of results obtained over time with the same test and the same individual; and 3) appropriate normative data, i.e., individual test scores must be comparable to test data from other individuals or groups of a similar nature, representative of that population.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WISC-R, for example, IQ's of 69 and below are characteristic of approximately the lowest 2 percent of the general population. In instances where other tests are administered, it would be necessary to convert the IQ score(s) to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by the IQ score(s).

In cases where more than one IQ is customarily derived from the test administered, i.e., where verbal, performance, and full-scale IQ's are provided as on the WISC-R, the lowest of these is used in conjunction with listing 112.05.

Tests meeting the above requirements are acceptable and encouraged for the determination of the conditions contained in the childhood mental disorders included in the listings. The psychiatrist or psychologist administering the test must have a sound technical and professional understanding of the tests and be able to evaluate the research documentation related to the intended application of the test.

In conjunction with clinical examinations, sources may report the results of screening tests, i.e., tests used for gross determination level of functioning. These tests do not have high validity and reliability and are not considered appropriate primary evidence for disability determinations. These screening instruments may be useful in uncovering potentially severe impairments, but must be supplemented by the use of formal, standardized psychological testing for the purposes of a final disability determination where such tests are required and available.

Where reference is made to developmental milestones, this is defined as the achievement of a particular mental or motor skill at an age-appropriate level, i.e., the skills achieved by an infant or young child sequentially and within a given time period in the motor and manipulative areas; in general understanding and social behavior; in self-feeding, dressing, and toilet training; and in language. This is sometimes expressed as a developmental quotient (DQ), or the relation between developmental age and chronological age as determined by specific standardized measurements and observations. Such tests include, but are not limited to, the Cattell Infant Intelligence Scale, the Bayley Scales of Infant Development, the Gesell Developmental Screening Test, and the Revised Stanford-Binet. Formal tests of the achievement

of developmental milestones are generally used in the clinical setting for determination of the developmental status of infants and toddlers.

Formal psychological tests of cognitive achievement are generally in use for preschool children, for primary school children, and for adolescents except for those instances noted below.

Exceptions to formal standardized psychological testing, when required, may be considered when a psychologist or psychiatrist who is qualified by training and experience to perform such an evaluation is not readily available. In such instances, appropriate historical, social, medical and other information must be reviewed in arriving at a determination.

Exceptions may also be considered in the case of ethnic/cultural minorities where the native language or culture is not principally English-speaking. In such instances, psychological tests which are culture-free, such as the Leiter International Performance Scale or the Scale of Multi-Culture Pluralistic Assessment (SOMPA) may be substituted for the preceding standardized tests. Any required tests must be administered in the child's principal language.

"Neuropsychological testing" refers to the administration of standardized tests which are reliable and valid with respect to assessing impairment in brain functioning. It is intended that the psychologist or psychiatrist using these tests will be able to evaluate the following functions: attention/concentration, problem solving, language, memory, motor, visual-motor and visual-perception, laterality and general intelligence (if not previously obtained).

E. *Effect of Hospitalization or Residential Placement:* As with adults, children with mental disorders may be placed in a variety of structured settings out-

side the home as part of their treatment. Such settings include, but are not limited to, psychiatric hospitals, developmental disabilities facilities, residential treatment centers and schools, community-based group homes and workshop facilities. The reduced mental demands of such structured settings may attenuate overt symptomatology and superficially make the child's level of adaptive functioning appear better than it is. Therefore, the capacity of the child to function outside highly structured settings must be considered in evaluating impairment severity.

On the other hand, there may be a variety of causes for placement of a child in a structured setting which may or may not be directly related to impairment severity and functionable ability. Placement in a structured setting in and of itself does not equate with a finding of disability. The severity of the impairment must be compared with the requirements of the appropriate listing.

F. Effects of Medication: Attention must be given to the effect of medication on the child's signs, symptoms and ability to function. While psychoactive medications may control certain primary manifestations of mental disorder, e.g., hallucinations, impaired attention, restlessness or hyperactivity, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychoactive medications, particular attention must be focused on the functional limitations which may persist. These functional limitations must be considered in assessing impairment severity.

Psychotropic medicines used in the treatment of some mental illnesses may cause drowsiness, blunted affect, or other side effects involving other body

systems. Such side effects must be considered in evaluating overall impairment severity.

112.01 Category of Impairments, Mental

112.02 Organic Mental Disorders: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests, including psychological or neuropsychological tests, demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and associated impairment of functional abilities.

The required levels of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of a deficit or loss of specific cognitive abilities or affective changes as medically documented by the persistence of at least one of the following:

1. Developmental arrest, delay or regression; or
2. Disorientation to time and place; or
3. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
4. Perceptual or thinking disturbance (e.g., hallucinations, delusions); or
5. Disturbance in personality; or
6. Disturbance in mood; or
7. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.); or
8. Impairment of impulse control (e.g., disinhibited social behavior); or
9. Impairment of cognitive function as demonstrated by neuropsychological assessment; and

B. Select the appropriate age group to evaluate the severity of the impairment:

1. For infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the following:

a. Gross or fine motor development 50 percent or less of the anticipated developmental norm documented by:

- (1) An appropriate standardized test; or
- (2) Clinical findings (see 112.00C of the preface);

or

b. Cognitive/communicative function 50 percent or less of the anticipated developmental norm as documented by:

- (1) An appropriate standardized test; or
- (2) Clinical findings of equivalent cognitive/communicative abnormality such as the inability to use simple verbal or nonverbal behavior to communicate basic needs or concepts; or

c. Social function 50 percent or less of the anticipated developmental norm documented by:

- (1) An appropriate standardized test; or
- (2) Clinical findings of an equivalent abnormality of social functioning as exemplified by serious inability to achieve age-appropriate autonomy as manifested by excessive clinging or extreme separation anxiety; or

d. A score of 65 percent or less of the anticipated developmental norm in two or more areas covered by a., b., or c. as measured by an appropriate standardized test or the appropriate clinical findings.

2. For children (age 3 to attainment of age 18), resulting in at least one of the following:

a. Marked impairment in age-appropriate cognitive/communicative function as documented by clinical examination and supported, if necessary, by the

results of appropriate standardized psychological tests, or for children under age 6, by appropriate tests of language and communication; or

b. Marked impairment in age-appropriate social functioning as documented by history and clinical examination and supported, if necessary, by the results of appropriate standardized tests; or

c. Marked impairment in personal/behavioral function as evidenced by:

(1) Marked restriction of age-appropriate activities of daily living as documented by history and clinical examination and supported by, if necessary, appropriate standardized psychological tests; or

(2) Persistent serious maladaptive behaviors destructive to self, others, animals or property requiring protective intervention; or

d. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete work-like tasks in a timely manner.

112.03 Psychotic Disorders: Characterized by a marked disturbance of thinking, feeling, and behavior. Occasionally psychotic disorders of adolescence must be more appropriately assessed under listing 12.03 of Part A of Appendix 1 because the medical criteria of this Part do not apply.)

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, for at least six months, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or
2. Catatonic or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech, with one of the following:

- a. Blunt affect; or
- b. Flat affect; or
- c. Inappropriate affect; or

4. Emotional withdrawal and/or isolation; and

B. Resulting in at least one of the appropriate age-group criteria in paragraph B of 112.02.

112.04 Affective Disorders: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome associated with at least four of the following:

- a. Anhedonia, apathy or pervasive loss of interest in almost all activities; or
- b. Appetite disturbances with change in weight or failure to make expected weight gains; or
- c. Sleep disturbance (e.g., insomnia or hypersomnia); or
- d. Psychomotor agitation, psychomotor retardation or hypoactivity; or
- e. Fatigue or loss of energy; or
- f. Feelings of worthlessness, self-reproach, or guilt; or
- g. Difficulty concentrating or thinking; or
- h. Recurrent thoughts of death, suicidal ideation, wishes to be dead, or suicide attempt; or

i. Hallucinations, delusions, or paranoid thinking; or

2. Manic or hypomanic syndrome associated with at least three of the following:

- a. Increased activity or physical restlessness; or
- b. Increased talkativeness or pressure of speech; or
- c. Flight of ideas or subjectively experienced racing thoughts; or
- d. Inflated self-esteem; or
- e. Decreased need for sleep; or
- f. Easy distractibility; or
- g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions, or paranoid thinking; or

3. Bipolar or cyclothymic syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes); and

B. Resulting in at least one of the appropriate age-group criteria in paragraph B of 112.02.

112.05 Mental Retardation: Characterized by significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested in the developmental period. The scores specified below refer to those obtained on the WISC-R, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning. See 112.00D.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Achievement of a pattern of developmental milestones generally acquired by children no more than one-half the child's chronological age; or

B. A valid performance, verbal or full scale IQ of 59 or less; or

C. A valid performance, verbal or full scale IQ of 60 to 69 inclusive and a physical or other mental impairment imposing additional and significant limitation of function; or

D. A valid performance, verbal or full scale IQ of 60 to 69 inconclusive and one of the following:

1. Marked impairment in social functioning; or
2. Marked impairment in personal/behavioral function.

112.06 Anxiety-Related Disorders: In these disorders, anxiety is either the predominant clinical feature or is experienced if the individual attempts to master symptoms; e.g., confronting the dreaded object or situation in a phobic disorder, attempting to go to school in a separation anxiety, or confronting strangers or peers in avoidant disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least one of the following:

1. Excessive anxiety manifested when the child is separated; or separation is threatened, from a parent or parent surrogate; or
2. Excessive and persistent avoidance of strangers; or
3. Generalized persistent anxiety or worry; or

4. A persistent irrational fear of a specific object, activity or situation which results in compelling desire to avoid the dreaded object, activity or situation; or

5. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

6. Recurrent obsessions or compulsions which are a source of marked distress; or

7. Recurrent and intrusive recollections of traumatic experience, including dreams, which are a source of marked distress; and

B. Resulting in at least three of the appropriate age-group criteria in paragraph of 112.02.

112.07 Disorders with Physical Manifestations: Manifested by physical symptoms for which there is no demonstrable organic etiology or known physiological cause.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least one of the following:

1. A persistent and serious disturbance of eating habits, accompanied by marked and unrealistic anxiety concerning appearance resulting in weight loss, emaciation, or other serious physical sequelae; or

2. Persistent and recurrent involuntary, repetitive, rapid, purposeless motor movements affecting multiple muscle groups with multiple vocal tics; or

3. Persistent nonorganic disturbance in one of the following:

- a. Vision; or
- b. Speech; or
- c. Hearing; or

- d. Use of a limb; or
- e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia); or
- f. Sensation (diminished or heightened); or
- g. Digestion or elimination; or
- 4. Unrealistic interpretation of physical signs or sensations associated with the fear or belief that one has a serious disease or injury, which persists despite medical reassurance; and

B. Resulting in at least three of the appropriate age-group criteria in paragraph B of 112.02.

112.08 Personality Disorders: Evaluate under 12.08 of Part A of Appendix 1.

112.09 Autism and Other Pervasive Developmental Disorders: Autism is a pervasive disorder characterized by significant social and communication deficits originating in the developmental period. Other pervasive developmental disorders are characterized by failure to develop age-appropriate social relationships, language disorders, ritualistic and compulsive behavior and, in most cases, retardation in intellectual development. Onset of the illness is in early childhood.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of the following:

- 1. For autism, at least two of the following:
 - a. Pervasive lack of responsiveness to other people; or
 - b. Gross deficits in language development; or
 - c. Bizarre responses to various aspects of the environment (e.g., resistance to change, peculiar in-

terest in or attachments to animate or inanimate objects); or

2. For pervasive disorders, at least three of the following:

- a. Sudden excessive anxiety manifested by such symptoms as free-floating anxiety, catastrophic reactions to everyday occurrences, inability to be consoled when upset, unexplained panic attacks; or

- b. Constricted or inappropriate affect, including lack of appropriate fear reactions, unexplained rage reactions, and extreme mood lability; or

- c. Resistance to change in the environment (e.g., upset if dinner time is changed), or insistence on doing things in the same manner every time (e.g., putting on clothes always in the same order); or

- d. Oddities of motor movement, such as peculiar posturing, peculiar hand or finger movements, or walking on tiptoe; or

- e. Abnormalities of speech, such as question-like melody, monotonous voice; or

- f. Hyper- or hypo-sensitivity to sensory stimuli, e.g., hyperacusis; or

- g. Self-mutilation, e.g., biting or hitting self, head banging; and

B. Resulting in at least one of the appropriate age-group criteria in paragraph B of 112.02.

112.10 Developmental and Emotional Disorders of Infancy (Birth to attainment of age 1): Developmental or emotional disorders of infancy are evidenced by a deficit or lag in the areas of motor, cognitive/communicative, or social functioning. These disorders may be related either to organic or to functional factors or to a combination of these factors.

The required level of severity for these disorders is met when the requirements of A, B, C, or D are satisfied.

A. Cognitive/communicative functioning 50 percent or less of the anticipated developmental norm as documented by appropriate clinical findings (e.g., infants 0-6 months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking, swallowing, or chewing) supported, if necessary, by a standardized test; or

B. Motor development 50 percent or less of the anticipated developmental norm documented by appropriate clinical findings, supported, if necessary, by a standardized test; or

C. Apathy, over-excitability or fearfulness demonstrated by marked impairment in one of the following:

1. Response to visual stimulation; or
2. Response to auditory stimulation; or
3. Response to tactile stimulation and positioning and environment; or

D. Failure to sustain social interaction on an ongoing, reciprocal basis as evidenced by:

1. Inability to participate in vocal exchanges, visual exchange and motoric gestural exchanges (including facial expressions) by 6 months; or
2. Failure to communicate basic emotional state such as a wish for closeness, desire to explore objects or people, or protest or anger by 9 months; or
3. Failure to attend to the caregiver's voice or face and/or to explore an inanimate object for a period of time appropriate to the infant's age.

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IN THE
Supreme Court of the United States

OCTOBER TERM, 1989

LOUIS W. SULLIVAN, Secretary of
Health and Human Services,

Petitioner,

v.

BRIAN ZEBLEY, et al.,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Third Circuit

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I. INTRODUCTION

Respondents file this brief in response to the Secretary's reply brief submitted to the Court on October 20, 1989. Pursuant to Rule 35.5, this brief is confined to a discussion of new matters raised by the Secretary in his reply brief, namely, pending legislation, contemplated changes in policy and the recent issuance of an agency staff report to the Senate Finance Committee concerning the SSI children's program.

II. THE PROPOSED LEGISLATION EVINCES CONGRESSIONAL DISAPPROVAL OF THE SECRETARY'S POLICY.

The Secretary has called attention to proposed legislation pending before the Congress concerning the Secretary's adjudication of children's SSI disability claims. (Reply Br. 18-19). The Secretary argues that, in light of the proposed legislation, the Court should overturn the Third Circuit's invalidation of his listings-only approach. (Reply Br. 19-20). In so arguing, the Secretary contradicts the contentions in his previous briefs to the Court.

In his opening brief, the Secretary argued that Congress has, by its silence, given *approval* of his stilted construction of 42 U.S.C. § 1382c(a)(3): "Congress has never drawn into question, much less altered, the Secretary's approach." (Pet. Br. 34-35). Now that Congress is in fact finally examining the issue that is the subject of this litigation, and adopting the *Zebley* court's finding that the Secretary's standards for adjudicating children's claims, far from being appropriate, are unnecessarily rigid and inflexible, *see Willeford v. Sec'y of HHS*, 824 F.2d 771, 774 (9th Cir. 1987) (Kennedy, J.) (referring to "mechanical" results from applying the listings-only approach in disabled widow(er)'s cases), he now argues that such viewpoints are irrelevant.

Pointed Congressional criticism has erupted now that the full import of the Secretary's listings-only policy has been brought to Congressional attention by the *Zebley* decision. In addition to the House bill cited by the Secretary, H.R. 3299, 101st Cong., 1st Sess., 135 Cong. Rec. H6131 (daily ed. Sept. 27, 1989) (passed as part of the budget reconciliation bill), two Senate bills also were proposed not long after the Third Circuit's decision.¹ These two bills, as well as the House bill cited by the Secretary, far from expressing disapproval of that decision, have embraced the substance of the Third Circuit's ruling. See H. R. 3299, § 10,222 (requiring "individualized assessment of the child's mental and physical impairments, including functional limitations, which prevent or significantly interfere with the activities of daily living appropriate to the age of the child.").

Similarly, the SSI Disabled Children's Eligibility Act of 1989, S. 1718 § 3(a), 101st Cong., 1st Sess. (Moynihan bill), "clarifies" current law so that "[p]oor disabled children should have the benefit of the same eligibility assessments available to disabled adults." 135 Cong. Rec. S12,472 (daily ed. Oct. 3, 1989) (statement of Sen. Moynihan). Section 3(a) of S. 1718 requires the Secretary to conduct "an assessment of the child's mental and physical impairments, including consideration of the limitations, singly and in combination, which prevent or significantly interfere with the activities of daily living." See also Supplemental Security Income Reform Act of 1989, S. 665, § 3(a), 101st Cong., 1st Sess., 135 Cong. Rec. S3110 (daily ed. Mar. 17, 1989) (Heinz bill) (child to be

¹ The Secretary omits reference to these bills, referring instead only to the Senate Finance Committee's recommendations for further study and internal, pre-effectuation reviews of decisions. (Reply Br. 19).

found disabled if he or she "suffers from any medically determinable physical or mental impairment which severely interferes with the activities of daily living. . . .").

In his comments accompanying the introduction of S. 665, Senator Heinz, citing examples of victims of the Secretary's current policies for adjudicating disability claims, noted that such people included a five-year old, Jason E.,²

who was denied SSI benefits and Medicaid because the *rigid medical criteria the Social Security Administration uses in determining disability in children does not adequately consider the functional limitations caused by the disease or illness*. When Jason first applied for SSI, his combination of medical and functional problems did not meet the inflexible criteria the SSA required. Jason suffered from muscular dystrophy. He had difficulty walking, could not hold a pencil, needed help dressing and eating, and had difficulty speaking because of deteriorating mouth and vocal cords Unfortunately, by the time he did get benefits, he was totally confined to a wheelchair and had to be carried by his family.

135 Cong. Rec. S3110 (emphasis added).

Rather than suggesting acquiescence in or approval of the Secretary's policy, the proposed legislation clearly demonstrates Congress' *dissatisfaction* with the Secretary's approach. This is in stark contrast to *Bowen v. Yuckert*, 482 U.S. 137, 151-52 (1987), where three Congressional reports had given express approval of the Secretary's regulation.

² Jason's case is described in the *amicus* brief of Pennsylvania Protection and Advocacy, et al. at 44-46.

Even if none of these bills is enacted, such lack of final legislation could not support a conclusion of Congressional approval of the Secretary's policies. While sustained Congressional attention to a particular administrative construction of a statute, followed by *repeated* refusals to take action, can, in some circumstances, warrant an inference of Congressional acquiescence, *see, e.g., Heckler v. Day*, 467 U.S. 104, 111-15, 118 n.30 (1984), this is the first session of Congress in which the issue before the Court has been specifically brought to Congress' attention. Further, Congress expressly considered the possibility that its pending action could be construed (or misconstrued) by the courts, and specifically disclaimed any position on this litigation.³

The bills pending in the Congress also demonstrate the weakness of the Secretary's position that a child's ability to engage in "age-appropriate activities," a standard utilized by the Secretary in his own regulations, *see* 20 C.F.R. § 416.994(c) (Resp. Br. 2a-3a), and his proposed children's mental health listings, 54 Fed. Reg. 33,238 (1989), is unworkable and "unduly subjective and ad hoc." (Reply Br. 16-18). Each of the three bills adopts an age-appropriate activities standard. Many in Congress thus

³ The Senate Finance Committee expressly disclaims any position on the correctness of *Zebley*: "[T]his and other amendments . . . should [not] be interpreted by the courts as either supporting or not supporting the concept that an individualized functional assessment must be used in determining whether a child meets the definition of disability." 135 Cong. Rec. S13,205 (daily ed. Oct. 12, 1989). Given that Congressional inaction in the face of proposed legislation addressing a judicial decision is generally considered an inadequate basis for inferring anything, *see, e.g., United States v. Price*, 361 U.S. 304, 310-11 (1960), it is a particularly unhelpful interpretive tool where Congress has expressly refused to take a position.

join respondents and *amici* in believing in the workability of such a standard.

III. FUTURE REGULATORY ACTIONS THAT MAY BE ADOPTED DO NOT SUPPORT REVERSAL.

The Secretary also raises a number of proposed and contemplated regulatory actions purportedly bearing upon the issues in this case. What the Secretary *may* do in the future and that he is "considering various . . . measures," and "possible revisions" (Reply Br. 19), can play no part in a challenge to the *existing* regulatory scheme. The possibility of action to mitigate, but not eradicate, the effect of illegal policies is an entirely improper basis for allowing such illegality to continue. Protestations of repentance and reform will not avail a defendant unless it can be shown that there is a definitive, permanent reversal of policy. *Gwaltney of Smithfield v. Chesapeake Bay Foundation, Inc.*, 484 U.S. 49, 66-67 (1987). While even speculative improvements that will help disabled children obtain benefits to which they are entitled are to be applauded, such possibilities are irrelevant to the very real dispute before the Court.

A. "Possible Clarification" Of The Equivalence Policy Is Of No Import.

In an apparent attempt to meet the argument that he fails to make individualized functional assessments and despite the express declaration of SSR 83-19 that the "functional consequences of the impairments . . . cannot justify a determination of equivalence" (J.A. 240) (emphasis in original), the Secretary now asserts for the first time that this policy "was not intended to bar consideration of the functional impact of an unlisted impairment in deciding whether it is equal in severity to a listed impairment." (Reply Br. 15 n.10). He goes on to state, despite this

asserted innocuousness of the Ruling, "that consideration is being given to a *possible clarification* of SSR 83-19 on this point." (*Id.*) (emphasis added).

A change in the almost decade-long policy of SSR 83-19 at this time evinces a confirmation by the Secretary of the *Zebley* court's and respondent's critique of the limitations of the listing-only approach. The exclusion of an assessment of functional criteria is at the heart of SSR 83-19 (promulgated in 1983 retroactive to 1980). The Ruling makes plain that it is

incorrect to consider whether the listing is equaled on the basis of an assessment of *overall* functional impairment The functional consequences of the impairments (i.e. RFC), irrespective of their nature or extent, *cannot* justify a determination of equivalence.

SSR 83-19 (J.A. 239-40) (emphasis in original). What euphemistically may be termed a "clarification" is more accurately termed an acknowledgement of error.⁴

⁴ As respondents have noted, the Secretary has taken starkly inconsistent positions on the relevance of a functional inquiry in making "equivalence" decisions. (Resp. Br. 32-33). In 1983, SSR 83-19, supplanting earlier instructions of 1974 endorsing such an inquiry (J.A. 97), declared that "[t]he functional consequences of the impairments . . . cannot justify a determination of equivalence." (emphasis in original).

In light of the clarity of this official proclamation, one wonders how any mere "clarification" could transform this specific prohibition into permission for "consideration of the functional impact of an unlisted impairment in deciding whether it is equal in severity to a listed impairment." (Reply Br. 15 n.10). To the contrary, if in fact the Secretary were to "clarify" SSR 83-19, so as to allow for consideration of the functional consequences, such clarification would constitute yet another about-face in his policy on equivalence. Such extraordinary lack of consistency belies the Secretary's contention that his interpretation of the statutory provision at issue has been "longstanding" and therefore is due deference. (Reply Br. 12).

B. Proposed Regulatory Action That May Be Taken Does Not Alter The Inherent Inadequacy Of The Listings-Only Approach.

Turning to possible regulatory action he might take, the Secretary points to the Notice of Proposed Rule Making ("NPRM") concerning the children's listings for mental impairments, and one concerning proposed listings for Down Syndrome and other Hereditary, Congenital and Acquired Disorders "scheduled for final publication in February 1990." (Reply Br. 19 n.6). Such proposals are of little significance as they do not bind the Secretary to do anything. See *American Trucking Ass'ns, Inc. v. Atchison, Topeka and Santa Fe Ry. Co.*, 387 U.S. 397, 415-16 (1967) (even final rules are subject to change). The Secretary's reliance upon these proposed administrative actions and the delay that is inevitable in their final adoption illustrates the inherent pitfalls of a listings-only approach as a means of adequately assessing a child's disabilities.

In April, 1986 after eight months of study, a group of experts convened by the Secretary recommended wholesale revision of the children's mental health listings.⁵ The Secretary took no action on these recommendations even though he recognized that they were needed to "ensure that the medical criteria are up to date and consistent with the latest advances in medicine." 52 Fed. Reg. 40,295 (1987). Instead, in October, 1987, the Secretary published a Regulatory Agenda announcing his intention to publish a NPRM in July, 1988, with a final rule scheduled for July, 1989. *Id.* at 40, 294-95. The Secretary finally published

⁵ The April 1, 1986 cover letter and the actual recommendations of the Work Group are found in the Joint Appendix filed with the Third Circuit at 124.

the NPRM more than one year behind schedule in August, 1989. 54 Fed. Reg. 33,238. Now we are informed that a final rule will be published but no date is given.

The fate of the long awaited listing for Down Syndrome tells a similar story. This listing was published as an NPRM in October 1987. Now, the Secretary alleges that it is scheduled for final publication in February, 1990, a delay of two and one-half years. Obviously, adopting a listing that recognizes the existence of Down Syndrome, a disease known to the medical profession for decades and one that affects 54,000 children, is hardly innovative.⁶ Such dilatory efforts are hardly an argument for overturning the Third Circuit's decision. Even these relatively easy steps take the Secretary years to adopt, leaving the listings far behind the state of the art and many children without needed benefits. Taken together, all this demonstrates the inherent inadequacy of relying upon a listings-only approach.

Children have had and are having their claims adjudicated, by the thousands, under what the American Medical Association has called the "woefully" outdated listings, Am. Br. of A.M.A. and Amer. Acad. of Pediatrics, et al. 22, inevitably leading to inappropriate denials as illustrated in the *amicus* briefs to the Court. *E.g.*, Am. Br. of Children's Defense Fund, et al. 8-33. While respondents have no objection to the listings as a valuable screening device, nor to their being brought up to date, the inherent lag between medical advances and the adop-

⁶ Down syndrome is just one of thousands of known childhood afflictions which the Secretary has no plans to incorporate at any point in the foreseeable future into his listings. See, *e.g.*, Am. Br. of A.M.A. and Amer. Acad. of Pediatrics, et al. 22 and Am. Br. of the Nat'l Easter Seal Society, et al. 17 n.9.

tion of new standards renders impossible an assessment of many disabilities when the listings are used as the *exclusive* guide.⁷ Unlike adults with impairments of "comparable severity," children are left with adjudication under outmoded standards.

IV. THE SECRETARY'S PRELIMINARY REPORT ON SSI CHILDHOOD DISABILITY SUPPORTS THE DECISION OF THE COURT OF APPEALS.

Along with his reply brief, the Secretary has lodged with the Court a remarkable report, SSA, Office of Disability, *Preliminary Staff Report: Childhood Disability Study* (Sept. 20, 1989) ("*Preliminary Report*"), that finds erroneous denial rates as high as 41.9% and makes recommendations for future policy changes, while attempting to cast the current system in the best light. This report, prepared by the Secretary for the Senate Finance Committee, touches on the issues in this case on several points: it demonstrates the inconsistent positions the Secretary has adopted on equivalence and it acknowledges the current system's failure to collect and consider all available evidence on functional impacts of impairments for *all* types of disabilities. Further, it urges inquiry into "age--

⁷ The Secretary proffers as relevant his "consideration" of revising other listings as also warranting an overturning of the Third Circuit's decision. (Reply Br. 19-20). He states that "[p]roposed revisions in the children's musculoskeletal and cardiovascular listings are in the latter stages of administrative review prior to publication of a notice of proposed rulemaking." (*Id.* 19 n.16). Yet, with the astonishing 29% error rate that the Secretary has acknowledged for children with cardiovascular disorders (Reply Br. 19 & n.15), an anticipated regulatory process of several years again serves to illustrate the inherent inadequacies in a listings-only approach. Promises of action at some indefinite point years in the future are cold comfort indeed for children currently being denied benefits.

appropriate activities" despite the Secretary's claim that such inquiry is "amorphous" and unworkable. Finally, it documents that the SSI children's program is grossly unfair and riddled with erroneous denials.

In his reply brief, the Secretary tries to harmonize the inconsistencies in his policy on equivalency (Reply Br. 15 n.10), one of several inconsistencies discussed in respondents' brief in chief. (Resp. Br. 27-33). In so doing, he fails to note yet another glaring inconsistency in this policy as recently revealed in the *Preliminary Report*. This report specifically found the errors in adjudication in mental disability equivalency cases to be "almost exclusively based on the failure to consider how all documented impairments combined to affect a child's overall functional capacity." *Preliminary Report*, Tab E, at 2 (emphasis added). The report goes on to conclude that "multiple impairments . . . must be . . . combined and considered with respect to the total limitation which they impose upon a child's functioning." *Id.*

In stark contrast, SSR 83-19 declares that "it is incorrect to consider whether the listing is equalled on the basis of overall functional impairment" (J. 239) (emphasis in original). Thus, in addition to SSR 83-19 constituting a departure from the SSA's original liberal equivalency policy (J.A. 97), a departure conceded by the Secretary (Reply Br. 15 n.10), the Secretary is apparently preparing to about-face, and plot yet another course with respect to his equivalency policy. Under these circumstances, it cannot seriously be contended that the Secretary's current interpretation of § 1382c(a)(3) has been "longstanding and consistently maintained" (Pet Br. 41), warranting any special deference.⁸

⁸ Respondents find no fault with the concept of a theoretically

The *Preliminary Report* also expends substantial energy explaining the large error rates found by SSA in its recent study. The report shows that clearly erroneous denials⁹ were made in 41.9% of growth impairment cases; 28.6% of cardiovascular cases; 12.5% of digestive impairment cases and 10.4% of mental health cases. *Preliminary Report*, Tab D, at Table 3. The report attempts to explain these shocking statistics as being primarily a function of "collection of information on activities of daily living not [being] uniformly documented." *Id.*, Tab A, at 2. It therefore goes on to propose a new policy which will "provide a more detailed picture of a child's daily activities and the effect of his physical and/or mental impairment on his ability to function." *Id.*, Tab B, at 2 (emphasis added). Of course, three of the four relevant listings make virtually no mention of functional limitations (Listing 100.00, 104.00 and 105.00); the mental health listings are acknowledged to be outmoded, requiring across-the-board limitations in function for a finding of disability.

Once again, respondents do not take issue with the Secretary's own criticisms of the SSI children's program

liberalized "equivalence" policy, as endorsed in the Secretary's *Preliminary Report*. However, given the Secretary's flip-flopping on this and other policies directly applicable to the adjudication of children's SSI claims, such pronouncements hardly provide assurance that he will issue directives to state disability agencies and ALJ's mandating individualized functional assessments, as required by the statute. At most, they demonstrate that, his narrow and inflexible policies having been called to the public and Congress' attention, the Secretary may now be willing to declare on paper a return to his original equivalency policy.

⁹ The *Preliminary Report* looked only at denials and used a standard of "clear error." The report is silent as to how clear error was defined or how many more children would have been found disabled if a functional approach rather than existing policies were used.

or with his suggestions for improvement. The problem with these suggestions, however, is that there simply is no regulatory vehicle for the Secretary to *consider* most of these "effects," once they are documented, under the rigid listings-only approach. Indeed, the Secretary notes that, with children, "the impairment's effect on the activities of daily living" is a "prime consideration"; *id.*, Tab B, at 3, but the report, without any authority or data, paradoxically finds the stilted listings-only approach to be adequate, with "functional considerations" required only under specific listings where such is deemed "appropriate." *Id.*, Tab F, at 1. In sum, the Secretary recognizes the importance of collecting data concerning the functional effects of *all* impairments but, in the same breath, deprives adjudicators of any means of considering this data, except where a claimant fits in a particular listings pigeon-hole that allows for the introduction of such evidence. Given such contradictory positions, it is not surprising that alarmingly high error rates are commonplace.

The *Preliminary Report*, like the bills pending before Congress, also belies the Secretary's contention that the standard of "age-appropriate activities," as an analogue to substantial gainful activity, is "amorphous" (Pet. Br. 44), or "difficult" and "unduly subjective." (*Id.* 16-18). In the report, the Secretary specifically delineates the categories of questions to which the proposed "national form," designed to detail the effects of the child's impairments "on his ability to function," would be directed: (1) any changes in the child's activities since the condition began, (2) the ability of the child to care for his or her personal needs, (3) problems with "getting along" with family members, teachers and peers, and (4) being able to be "fully understood" by family, friends and strangers. *Pre-*

liminary Report, Tab B, at 2-3. In the case of mental impairments, the Secretary elaborates on certain of these categories of age-appropriate activities as including: (1) ability to communicate, (2) level of cognitive function, and (3) socialization skills. *Id.*, Tab E, at 1. Further, the report notes that the revised mental listings are designed to address "age-appropriate functioning within the cognitive/communicative, social, personal/behavioral and concentration/persistence/pace developmental domains." *Id.*, Tab E, at 3 (emphasis added). Such inquiries show that the Secretary has virtually capitulated on a number of respondent's arguments; what remains is for the Secretary to adopt a decision-making process that allows for functional assessments to be made.

Respondents do not suggest that it will be a simple task for the Secretary to assess a child's impairments and how they effect the ability to engage in age-appropriate activities.¹⁰ However, such a task is not unmanageable, as his own *Preliminary Report* concedes. Indeed, the Secretary already acknowledges therein that "additional effort may be needed in obtaining clear and comprehensive descriptions of developmental attainment and progression in the areas of communication, cognitive functioning and socialization skills, particularly in claimants aged 4 to 18." *Preliminary Report*, Tab E, at 1. Given this acknowledgement, it can hardly be contended by the

¹⁰ Respondents note that an inquiry into function and its effect upon the ability to engage in age-appropriate activities is the only inquiry that they have suggested as a means of identifying childhood disabilities of "comparable severity." Thus, the Secretary's contention that respondents want him "to consider . . . unspecified non-medical factors (similar to the non-medical factors of age, education and work experience for an adult)" (Reply Br. 1), is baseless.

Secretary in this litigation that the age-appropriate standard is amorphous and unworkable.

V. CONCLUSION

For the foregoing reasons and those stated in respondents' opening brief, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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In the Supreme Court of the United States

OCTOBER TERM, 1989

LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

SUPPLEMENTAL BRIEF FOR THE PETITIONER

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Pursuant to Rule 35.5 of the Rules of this Court, the Solicitor General, on behalf of the Secretary of Health and Human Services, respectfully files this supplemental brief to inform the Court of recent legislative and administrative developments that have a bearing on the issues in this case.

1. *Legislative Developments.* We informed the Court in our reply brief (at 18-19) that Congress was considering several provisions affecting the children's disability program as part of the omnibus reconciliation bill for fiscal year 1990. We wish to inform the Court that those provisions have been deleted from the bill, which passed the House of Representatives and the Senate early in the morning of November 22, 1989.

The House of Representatives passed a version of the budget reconciliation bill on October 5, 1989, that would have affected the SSI children's disability program in

several respects. Gov't Reply Br. 18-19 & n.13. Of particular relevance here, that bill would have amended Title XVI, effective October 1, 1989, expressly to require an "individualized assessment" of a child's impairments that "prevent or significantly interfere with the activities of daily living appropriate to the age of the child." H.R. 3299, 101st Cong., 1st Sess. § 10222 (1989) (135 Cong. Rec. H6131 (daily ed. Sept. 27, 1989)).

The Senate Budget Committee's budget reconciliation bill, which was based in this respect on recommendations by the Senate Finance Committee, omitted any such provision.¹ Instead, that bill would have established a 15-member Commission to study the definition of disability under Title XVI as it applies to determining whether a child under age 18 is eligible to receive benefits. S. 1750, 101st Cong., 1st Sess. § 5001 (Oct. 12, 1989). In particular, the Commission would have considered: (A) "whether individualized functional assessments of children can appropriately be used in determining disability, and if a determination of appropriateness is made, the types of assessment and criteria to be employed"; and (B) recommendations for revisions of the Part B Listing for children, "including the degree to which age-appropriate medical and functional criteria can validly be included in such Childhood Listing of Impairments." *Id.* § 5001(e)(2)(A) and (B). Other provisions of the Senate Committee's bill would have: required pediatricians to participate in disability determinations affecting children (*id.* § 5002(a)), sought to enhance decision-making by mandating that the Social Security Administration (SSA) review at least 50% of all state-agency decisions that a child is not disabled (*id.* § 5002(b)), and required the Secretary to submit to Congress a schedule for the updating and revision of

¹ The Senate Committees thus declined to accept the proposals in the bills introduced by Senator Heinz and Senator Moynihan, cited by respondents (Supp. Br. 2-3).

Part B of the Listing of Impairments for children (*id.* § 5002(c)). See 135 Cong. Rec. S13,205 (daily ed. Oct. 12, 1989). However, all of the SSI children's disability proposals were deleted (along with many other provisions) from the version of the budget reconciliation bill that passed the Senate on October 13, 1989. *Id.* at S13,369 (daily ed. Oct. 13, 1989).²

Like the Senate-passed version of H.R. 3299, the budget reconciliation bill reported by the Conference Committee on November 20, 1989, omitted the SSI provisions in the House-passed bill, as well as the Senate Committees' proposals. The bill reported by the Conference Committee was passed by the House of Representatives and the Senate on November 22, 1989. Congress thus declined to adopt the House provision that would have restructured the disability determination process for children.

2. *Administrative Developments.* a. On November 21, 1989, the Secretary of Health and Human Services announced several initiatives concerning the children's disability program (App., *infra*, 1a-2a), in order "to better ensure that needy children with severe disabilities receive the Supplemental Security Income benefits to which they are entitled." *Id.* at 1a. The Secretary explained that "[i]n our efforts to strive for the best possible program administration, we constantly watch how we are managing our programs." *Ibid.* In this con-

² In considering the budget reconciliation bill on October 13, 1989, the Senate first adopted Amendment 1004, which deleted the children's disability provisions and all other matter from S. 1750 that did not reduce the deficit. See 135 Cong. Rec. S13,349, S13,357 (daily ed. Oct. 13, 1989). The Senate then substituted the text of S. 1750, as so amended, for the text of H.R. 3299 as it passed the House, and passed this substitute version of H.R. 3299. *Id.* at S13,368-S13,369. The Senate-passed bill is printed in the Congressional Record of October 18, 1989, and shows that Sections 5001 and 5002 of S. 1750, which addressed SSI disability determinations in children, were deleted. 135 Cong. Rec. S13,692, S13,701 (daily ed.).

nection, the Secretary noted that the Social Security Administration (SSA) recently released preliminary findings from a study that reviewed decisions made in childhood disability cases, and that those findings indicated that certain categories of such cases warrant more attention. *Ibid.*; see pages 6-8, *infra*. The Secretary's November 21 statement announces four initiatives in response to these preliminary findings (App., *infra*, 1a-2a):

(1) all disability claims for children from birth through age three, and claims for older children whose impairments give rise to a greater likelihood of error, will be reviewed twice before they can be denied;

(2) all entities that adjudicate and review children's disability claims will include pediatricians among their medical personnel;

(3) an across-the-board review of the existing medical criteria for all childhood impairments will be undertaken (a process that was begun with the publication of the notice of proposed rulemaking to expand the criteria for evaluating mental impairments in children (54 Fed. Reg. 33,238 (Aug. 14, 1989), discussed in Gov't Reply Br. 4-5);³ and

³ This reassessment also is reflected in the new listing for Down Syndrome and other Hereditary, Congenital and Acquired Disorders, which was published in proposed form in October 1987 (52 Fed. Reg. 37,161) and is scheduled for publication in final form in February 1990. Contrary to respondents' contention (Supp. Br. 8), the absence of a specific listing for Down Syndrome and other disorders covered by this proposal at the present time does not mean that otherwise qualified children with those disorders have heretofore been denied benefits. Such children are found eligible if they meet or equal other provisions of the current Listing. For example, children with Down Syndrome typically are evaluated under the listing for mental retardation (§ 112.05), and, depending on associated physical problems, under the growth impairment (§ 100.00), cardiovascular (§ 104.00), or other body system categories. Fox & Greaney, *Disabled Children's Access to Supplemental Security Income and Medicaid Benefits* 48 (Dec. 1988) (lodged with the Clerk by respondents).

(4) education and training of all disability examiners and medical personnel will be intensified to ensure complete understanding of the requirements for adjudicating children's disability claims.

b. The preliminary findings to which the Secretary referred in announcing his initiatives on November 21 are those contained in the report prepared by SSA for the staff of the Senate Finance Committee in connection with its consideration of the pending legislation, discussed above. See SSA, Office of Disability, *Preliminary Staff Report: Childhood Disability Study* (Sept. 20, 1989) [hereinafter *Preliminary Report*]. We lodged a copy of the *Preliminary Report* with the Clerk of this Court when we filed our reply brief at the merits stage, and it is mentioned in our reply brief (at 19 & nn. 15, 16) and discussed in respondents' supplemental brief (at 9-14), which we received in typescript on November 13, 1989, and in printed form on November 17, 1989.

The study on which the *Preliminary Report* was based reviewed 927 children's disability cases decided by state agencies in which benefits were denied, in order to determine whether cases are being correctly decided under the existing Listing and to determine whether the criteria in the Listing adequately identify disabled children who meet the general level of impairment severity articulated in the Act and regulations. *Id.* Tab C, at 1. The *Preliminary Report* found that in the entire sample of 927 surveyed cases, the overall rate of erroneous denials under existing standards was approximately 6.4% (*id.* Tab D, Table 2), which HHS informs us does not differ significantly from the range of error that is experienced under the disability programs generally.⁴ How-

⁴ Of course, individuals whose claims were denied at the initial determination stage on the basis of the state agency's finding may seek reconsideration of that denial and then may also seek an ALJ hearing and Appeals Council review to correct any error in the preliminary stages of the review process. We have been informed

ever, the *Preliminary Report* did identify several categories of impairments for which the error rate may be considerably higher.⁵ The tentative error rate of 41.9% for growth impairments was of particular concern (*id.* Tab A, at 2; Tab D, Table 3), as was the error rate of 10.4% for mental impairments (*id.* Tab D, Table 3), since approximately 60% of all childhood disability claims involve allegations of a mental impairment (*id.*, Tab E, at 1). The *Preliminary Report* concluded that the initial review of the study findings "provides no indication that there are any overall or generalized problems with the childhood disability evaluation criteria," but that "the criteria for several specific impairments may need to be reevaluated and revised" and that "certain impairment categories may be more prone to adjudicator error." *Id.* Tab F, at 1.

The initiatives announced by the Secretary on November 21 respond to these findings and are based on similar recommendations in Tab F of the *Preliminary Report*. Those initiatives demonstrate the Secretary's determination to ensure that the children's disability program is

by HHS that cases in which the claimant sought further review and was found disabled at later stages of the review process were excluded from the sample.

⁵ The small sample size for several categories renders the percentage rate subject to a very high margin of error. *Preliminary Report* Tab C; *id.* Tab D, Table 2 (note). For example, we have been informed by HHS that, because of the small sample size for cardiovascular claims, the rate of erroneous denials of 28.6% (*id.* Tab D, Table 2) is itself subject to a sampling error of $\pm 25\%$. The *Preliminary Report* also urges caution in the use of the raw data because the cases were not drawn entirely at random. The study was designed to ensure that cases would be drawn from four age groupings and specific impairment categories, and the percentages in the *Preliminary Report* have not yet been weighted to compensate for this sampling methodology. *Id.* Tab C; *id.* Tab D, Table 2 (note). We have been informed by HHS that the data will be weighted and refined in the final report based on the study, which is due to be issued early in 1990.

administered in a fair and sound manner and to review and, where appropriate, revise the criteria in the Listing of Impairments in light of experience. By the same token, the Secretary's actions address several matters (review of certain denials to ensure proper application of standards, use of pediatricians, and review of the children's listings) that were the subject of the legislative proposals that Congress deleted from the budget reconciliation bill. These measures underscore that modifications of the children's disability program are properly committed to the Secretary and Congress, not the courts.

c. The discussion in respondents' supplemental brief (at 9-14) of the *Preliminary Report* that underlies the Secretary's recent actions is misleading in two important respects. First, respondents argue (Supp. Br. 10) that the *Preliminary Report* is inconsistent with Social Security Ruling (SSR) 83-19, which, in their view (Supp. Br. 5-6, 10), altogether prohibits consideration of the functional impact of an impairment (or combination of impairments) in determining whether it equals the Listing. However, as we have explained in our reply brief (at 15 n.10), SSR 83-19 does not bar consideration of impairment-related functional limitations in determining whether an impairment is of sufficient severity to equal a listed impairment. The passages in SSR 83-19 upon which respondents rely (J.A. 239-240) merely stress that an equivalency determination is not to be made on the basis of an assessment of residual functional capacity (RFC), as respondents urge, or solely on the basis of an overall assessment of functional impact that is not tied closely to the criteria in the Listing.

The *Preliminary Report* in fact confirms that SSR 83-19 does not rule out consideration of impairment-related functional limitations in making an equivalency determination, because it states that the errors identified in cases in the study sample that should have been found to equal the mental impairment listing were "almost exclusively based on the failure to consider how all docu-

mented impairments combined to affect a child's overall functional capacity." *Id.* Tab E, at 2.⁶ As respondents concede (Supp. Br. 10), the Secretary also made clear at the outset of the SSI program that impairment-related functional limitations could be taken into account in appropriate circumstances in making an equivalency determination. J.A. 97. The Secretary's position on this issue therefore has been consistent throughout.—In attempting to paint a picture of administrative inconsistency in this regard, respondents construe SSR 83-19 in a manner that is contrary not only to the Secretary's interpretation of his own administrative ruling (compare *Udall v. Tallman*, 380 U.S. 1, 16-17 (1965)), but also to their own interests, which presumably are served by a policy that takes impairment-related functional limita-

⁶ This same understanding is set forth in the training manual for physicians who review claims under the disability programs. SSA, Office of Disability, *Physician Training Manual on Impairment Evaluation* (June 1988). The introduction to that *Manual* states (at 10):

Medical equivalency permits a physician to arrive at a judgment that the findings, although not exactly matching the listed criteria, have the same effect as a listed impairment with regard to inability to perform work-related activities for at least 12 months or result in death. In addition, individuals may have more than one impairment or a combination of impairments, none of which alone matches in its clinical presentation, the criteria that are listed, but *together*, the findings as presented have the same impact on inability to perform gainful activity for at least 12 months or result in death as the findings provided in a listed impairment. Under these circumstances, the physician may arrive at a judgment of "equals the listings." Caution should be used in arriving at equals decisions to avoid misuse in inadequately documented cases and in cases of lesser than listing severity. Great care must be taken to provide a thorough and complete rationale for this decision.

This passage discusses equivalency determinations for adults, but the point that impairment-related functional limitations may be taken into account in an equivalency determination would apply equally to children. We have lodged a copy of the *Physician Training Manual* with the Clerk of this Court.

tions into account in an equivalency determination in appropriate circumstances.

Second, respondents erroneously assert (Supp. Br. 9-10, 11-13) that the *Preliminary Report* actually supports the notion that the Act requires an individualized assessment of a child's RFC and non-medical factors similar to an adult's vocational factors of age, education and work experience. They rest this assertion on the fact that the *Preliminary Report* discusses the importance of collecting data on a child's activities of daily living (*id.* Tab A, at 2; Tab B, at 2)⁷ and acknowledges that the impact of an impairment on age-appropriate activities warrants particularized consideration under the Listing in appropriate circumstances, especially in the case of mental impairments (*id.* Tab E, at 1-3; *id.* Tab F, at 1). What respondents ignore is that, as the *Preliminary Report* makes clear, the regulatory framework that has been in place for more than 15 years provides for consideration of activities of daily living and impairment-related functional limitations, where appropriate, for purposes of measuring the severity of the impairment itself—i.e., in determining whether the individual's impairment meets or equals the Listing. That is something quite different from the approach respondents propose, which would cut the disability determination loose from the objective measures of impairment severity in the Listing and instead require an RFC/non-medical-factors assessment of children—albeit without the benefit of an objective benchmark (parallel to an adult's ability to work) against which to make such an assessment.

⁷ The current application form to be completed by or on behalf of individuals seeking children's disability benefits requests information about the applicant's activities of daily living. Form SSA-3820-F6, question 13, included in *Preliminary Report* Tab B. SSA is considering the promulgation of a uniform nationwide form that solicits more detailed information in this area. *Preliminary Report* Tab B, at 2.

For the foregoing reasons and those set forth in our opening and reply briefs, it is respectfully submitted that the judgment of the court of appeals should be reversed.

KENNETH W. STARR
Solicitor General

NOVEMBER 1989

APPENDIX

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE Phil Gambino
Tuesday, November 21, 1989 (202) 245-6764
Frank Battistelli
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HHS Secretary Louis W. Sullivan, M.D. issued the following statement today:

"As Americans we all take great pride in the protection we can provide to the vulnerable children of this great country. We in the Department of Health and Human Services provide much of this protection and support for families with disabled children through the Supplemental Security Income program administered by SSA.

"Today I am taking actions to better ensure that needy children with severe disabilities receive the Supplemental Security Income benefits to which they are entitled. I want to be personally assured that all needy children entitled to disability benefits receive them and the critical medical coverage that often accompanies receipt of SSI through eligibility to the Medicaid program.

"In our efforts to strive for the best possible program administration, we constantly watch how we are managing our programs. The Social Security Administration has recently released preliminary findings from a study looking at decisions made in childhood disability cases. Findings include the fact that certain children's case categories warrant more attention.

- "Today I am directing that all claims for disabled children from birth through age three be reviewed

twice before a claim is denied. Likewise, claims involving older children with impairments which have been found to have greater likelihood of error will also receive a double review.

- "I am directing all entities that adjudicate and review SSA childhood claims to include pediatricians among their medical personnel. All the medical personnel involved in the disability program are familiar with adjudicating childhood claims. Even so, pediatricians are specialists in those factors concerned with the growth and development of children. Likewise other specialists will continue to be involved in appropriate childhood claims.
- "I am directing an across-the-board review of the medical criteria for all childhood impairments. This process was recently begun with the publication of a notice of proposed rulemaking to expand the criteria for evaluating mental impairments in children. I have asked the Commissioner of Social Security to ensure that all of the medical listings applicable to children be reviewed and revised as soon as practical.
- "I am directing that a special effort be given to intensifying the education and training of all disability examiners and medical personnel to ensure a complete understanding of the requirements for adjudicating childhood claims in the disability program. Because 1 in 15 claims is filed on behalf of a child, greater emphasis is needed to assess the unique issues in deciding childhood claims."

IN THE
Supreme Court of the United States

OCTOBER TERM, 1989

LOUIS W. SULLIVAN, Secretary of
Health and Human Services,
Petitioner,
v.
BRIAN ZEBLEY, et al.,
Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Third Circuit

RESPONDENTS' SECOND SUPPLEMENTAL BRIEF

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I. INTRODUCTION

Respondents file this brief to address the Secretary's supplemental brief submitted to the Court on the eve of the November 28, 1989 argument of this case. Pursuant to Rule 35.5, this brief is confined to a discussion of new matters, including those raised by the Secretary, namely, his press release announcing non-regulatory changes in the children's SSI program and the status of legislation in Congress.

II. THE SECRETARY'S BELATED COSMETIC IMPROVEMENTS IN THE SSI CHILDREN'S PROGRAM LEAVE UNCHANGED THE FUNDAMENTALLY INFERIOR EVALUATIONS CHILDREN RECEIVE IN COMPARISON TO ADULTS

Six years after this action was filed and seven days before oral argument, the Secretary has issued a press release announcing the following changes in the SSI children's program: (1) a second review, under current unchanged standards, before a denial of benefits may be issued for children under age three or for older children who are suffering from an impairment that the Secretary has found to be subject to high error rates (in his *Preliminary Staff Report: Childhood Disability Study*, Sept. 20, 1989, lodged with the Court); (2) the requirement that adjudicative entities include pediatricians on their staff; (3) review of the medical criteria for all childhood impairments; and (4) education of examiners and medical personnel to insure understanding of current requirements. See Press Release of HHS Secretary Louis W. Sullivan (Nov. 21, 1989) (Pet. Supp. Br. 1a-2a.)

These changes fall far short of what the *Zebley* court held was required by Congress, namely, a beyond-the-listings, individualized assessment of the functional limitations of "any" childhood mental or physical impair-

ment. They also on their face are grossly inadequate to address the endemic arbitrariness in the Secretary's adjudication of childhood disability claims.

First, it is clear that there is no remedy, much less recognition, in this last minute, extra-regulatory announcement of the fundamental failure of the program to evaluate the various effects on the child's daily living activities of a host of childhood afflictions, such as spina bifida, cystic fibrosis, muscular dystrophy, mental retardation, etc., which respondents and all *amici* have shown cannot meet or equal current standards. The Secretary recognized this critical failing in his Reply Brief, wherein he attempted to address the bald declaration of Social Security Ruling 83-19 that "it is incorrect to consider whether the listing is equaled on the basis of an assessment of *overall* functional impairment," and that the "functional consequences of the impairments . . . cannot justify a determination of equivalence [to the impairment listings]" (J.A. 239-40) (emphasis in original). The Secretary, in light of this ruling, represented to this Court "that consideration is being given to a possible clarification of SSR 83-19 on this point." (Reply Br. 15 n.10). It is now obvious that the Secretary has refused to make any change in SSR 83-19, which leaves unremedied his deficient evaluation of functional limitations of children suffering from the above-identified afflictions and numerous others. See, e.g., Am. Br. of A.M.A. and Amer. Acad. of Pediatrics, et al. 8-33; 22; and Am. Br. of the Nat'l Easter Seals Society, et al., n.9.¹

¹ The vices of SSR 83-19 have been set forth in detail in the Amicus Brief of the Nat'l Easter Seals Society et al., 13-17. The Secretary's tortured attempt to negate the plain language of SSR 83-19, and to somehow harmonize it with the diametrically contrary statements on equivalency contained in his *Preliminary Staff Report*, Tab. E, at 2, and in his Reply Brief, 15 n.10, is frivolous. (Pet. Supp. Br. 6-8). SSR 83-19 remains unaltered as the authoritative national policy pronouncement binding on all the Secretary's disability adjudicators.

Second, the "double review" proposed for infants and classes of cases involving shockingly high error rates (see Resp. Supp. Br. 22), becomes a bureaucratic exercise when the second review, after an initial denial has been rendered, would be premised on the *same* faulty standards and procedures utilized for the first decision. Unless the Secretary is ready to evaluate, for example, the impact of many hours of necessary daily pulmonary toileting of a cystic fibrosis child and the debilitating effects of repeated infections and hospitalizations for such a child, a "second" review adhering to unrealistic listings criteria, accomplishes little and masks an inherently arbitrary adjudication system. Similarly, the availability of pediatrician review is inherently inadequate where the pediatrician, as any other agency physician, must apply the same outmoded and rigid listings.² Finally, educating disability examiners as to *current* requirements for adjudicating childhood claims is a further bureaucratic exercise ignoring the inadequacies of current inferior standards and procedures for evaluating childhood cases.

Third, the proposed "review" of the listings at some uncertain date in the future is both too vague and too late to remedy the claims in this action. The Secretary is only belatedly responding to the widespread consensus in the medical community that the childhood listings, virtually unchanged since issued in 1977, are "woefully" outdated, Am. Br. of A.M.A. and Amer. Acad. of Pediatrics, et al. 22.³ The snail-like pace of revisions being considered,

² The Secretary's announcement merely directs adjudicative entities "to include pediatricians among their medical personnel," far short of requiring that a pediatrician be utilized in each childhood case.

³ The Secretary's defense of the absence of a Down Syndrome listing (Pet. Supp. Br. 4, n.3), despite its longstanding recognition by the medical community, is belied by the Amicus brief of the National Down Syndrome Congress. See Am. Br. of the Nat'l Easter Seals Society, et al. 17, n.9.

such as the still-pending consideration of a Down Syndrome listing, over two years since the NPRM was published and many decades after the medical community had identified this childhood malady (*see* Resp. Supp. Br. 8), itself bespeaks the inadequacy of revisions of particular listings. More fundamentally, listings have never addressed, nor has the Secretary in his press release proposed their addressing, the absence of any realistic, individualized functional assessment step, similar to the adult's RFC evaluation. The Secretary's announcement also fails to address the listings inability to take into account functional consequences of disabilities such as the combined impact of multiple impairments, the presense of pain (which is nowhere mentioned in any existing or proposed adult or childhood listing), the effects of medication, etc. (*see* Resp. Br. 21-24). Likewise, the Secretary's proposed review does not address the equally fundamental flaw that the listings explicitly impose on children the stricter Widow's Disability test of "any gainful activity," which the Congress refused to legislate for the children's SSI program. (*Id.* at 25-26).

III. THE RECENT CONGRESSIONAL RECESS IS OF NO IMPORT

The Secretary reports deletion from the 1989 budget reconciliation act by the 101st Congress in its first session of all legislative provisions "that did not reduce the deficit." (Pet. Supp. Br. 2, n.2). As the Secretary noted in his Brief (*id.* 2), the provisions which would have clarified existing law to require realistic, individualized assessments of functional limitations of children beyond the listings were just one of "many provisions" deleted solely because they were non-deficit reducing.

The *Zebley* case had awakened Congress for the first time to the gross inequities in the SSI childhood program

and all the legislation introduced this year in both the House and Senate is uniformly critical of the Secretary's policies as not comporting with the intent of Congress (*see* Resp. Supp. Br. 1-5). Congress has now recessed without completing action on this proposed legislation, but these bills are still pending. Given the press of deficit reducing legislation, Rep. Thomas J. Downey, Chairman of the Subcommittee on Human Resources of the Committee on Ways and Means, a chief sponsor of the House bill, H.R. 3299, 101st Cong., 1st Sess., 135 Cong. Rec. H6131 (daily ed. Sept. 27, 1989), anticipated that these provisions might not pass in the first session:

If these provisions do not pass this year, I intend to bring them to the floor again next year. Everyone should understand that if Congress fails to act on these provisions this year, it in now way reflects on their merits. Poor disabled children should receive individual functional assessments. It is fair, it is right, and they will receive functional assessments as soon as we can complete legislative action.

Statement of Rep. Downey, 135 Cong. Rec. E3930 (Nov. 17, 1989). Rep. Downey's statement mirrors a similar statement issued by the Senate Finance Committee last month disclaiming any inference to be drawn by the courts from Senate action. *See* 135 Cong. Rec. S13,205 (daily ed. Oct. 12, 1989). (Resp. Supp. Br. 4, n.3). *See also United States v. Price*, 361 U.S. 304, 310-11 (1960) (congressional inaction in face of proposed legislation addressing a judicial decision is inadequate basis for inferring anything).

The Secretary can find little comfort in a Congress that has refused to give any approval to his current policies and is considering alternative clarifications, all of which reject the Secretary's current interpretation of the Act.

IV. CONCLUSION

For the foregoing reasons and those stated in respondents' prior briefs, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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NO. 88-1377

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IN THE

Supreme Court of the United States

October Term, 1989

LOUIS SULLIVAN,
SECRETARY OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

BRIAN ZEBLEY, JOSEPH LOVE, JR., et al.,
Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

**BRIEF FOR THE AMICI CURIAE
IN SUPPORT OF RESPONDENTS**

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SICKLE CELL GENETIC DISEASE COUNCIL
PARENTS INVOLVED NETWORK
MEDIA CHILD GUIDANCE
ERIE INDEPENDENCE HOUSE
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DOWN SYNDROME TODAY

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SUMMARY OF ARGUMENT

In order to effectuate its intent to provide financial assistance to disabled children in low-income families who are "certainly among the most disadvantaged of all Americans,"¹ Congress mandated that a child be eligible for Supplemental Security Income ("SSI") if he or she meets the income requirements and is disabled by "any medically determinable physical or mental impairment of comparable severity" to one that would render an adult eligible for SSI benefits.²

Despite this clear statutory mandate, the Secretary of Health and Human Services ("Secretary") has adopted by regulation two very different processes for determining disability of SSI applicants, depending on whether the

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1. H.R. Rep. No. 231, 92nd Cong., 2d Sess. 1, 147-48, reprinted in 1972 U.S. Code Cong. & Admin. News 4989, 5133-34.
 2. 42 U.S.C. § 1382c(a)(3)(A) (emphasis added).

applicant is a child or an adult. In blatant disregard of Congressional language and intent, the process applied to children is dramatically more restrictive than that applied to adults.

For adults, the Secretary engages in a comprehensive, two-tiered process. That process begins with an abbreviated approach, designed for administrative convenience, which compares an adult's impairments to the Secretary's Listing of Impairments ("Listings").³ If the adult's impairments do not "meet or equal" those within the Listings, the Secretary proceeds to the second tier of the

3. The Listing of Impairments, 20 C.F.R. Part 404, Subpart P, App. 1 (Jt. App. at 115-235) is a catalog of medical findings descriptive of certain diseases and disabilities. The Listings are divided into two parts. Part A is applied to adults 18 years of age and older and "may also be applied in evaluating impairments in persons under age 18 if the disease processes have a similar effect on adults and younger persons." 20 C.F.R. § 416.925(b)(1). Part B is applied solely to persons under the age of 18. 20 C.F.R. § 416.925(b)(2).

process -- an assessment of residual functional capacity ("RFC") -- which entails an evaluation, on an individualized basis, of the full effect of the claimant's functional limitations.

The Secretary's two-tiered process for determining disability in adult claimants stems from the recognition that evaluating an individual's impairments solely in terms of the Listings is insufficient. The Listings are not -- and cannot ever be -- sufficiently comprehensive to enable the Secretary to consider combinations of impairments, the impact of impairments on a claimant's ability to function, the interaction of various impairments, or subjective factors, such as pain, dizziness, or side effects of medication. Accordingly, the Secretary's evaluation process for adults includes both an abbreviated, Listings-based approach and an individualized assessment of functioning if the individual's impairments do not meet or equal those within the Listings. The Secretary has thus implic-

itly conceded that the Listings -- by themselves -- do not work in all cases.

In sharp contrast to the process for adults stands the process for children, which begins and ends with a determination of whether the child's impairments can be pigeonholed into the Listings. If the child's impairments "meet or equal" those within the Listings, he or she gets benefits; if they do not, he or she is denied benefits -- without any consideration whatsoever of the effects of the impairments on the child's functional abilities, the combined effect of multiple impairments, or subjective factors. Thus, unlike the evaluation process accorded adults, there is no opportunity for children to demonstrate that their functional limitations render them disabled.

A unanimous panel of the United States Court of Appeals for the Third Circuit struck down the Secretary's process for determining disability in children as flatly inconsistent with the statute, holding that the regulations

"do not provide for [an] individualized assessment for children, although they are entitled by statute to receive benefits if suffering from 'any' impairment of 'comparable severity'" to one that would entitle an adult claimant to benefits. Zebley v. Bowen, 855 F.2d 67, 73 (3d Cir. 1988). The court of appeals determined that the Listings "do not purport to be an exhaustive compilation of medical conditions which could impair functioning to the extent necessary to satisfy the statutory standard for disability," yet only adults are given the opportunity to demonstrate disability through a further individualized, functional assessment. Id. at 73. "Persuaded that in the statutory directive that 'any' impairment may be disabling if severe enough, Congress has clearly expressed an intention that children be given the opportunity for individual evaluations comparable to the residual functional capacity assessment for adults," the court held that "an individualized determination of the degree of functional incapacitation is required by statute during

the disability determination process for children." Id. at 76.

Amici Curiae urge this Court to affirm the decision of the court of appeals.

INTERESTS OF AMICI CURIAE

Amici Curiae represent children with severe and often debilitating handicaps who have been or may in the future be denied SSI benefits because of the Secretary's truncated and formalistic approach. Amici are deeply concerned that disabled children receive a fair opportunity to obtain disability benefits. Amici, which consist of almost every major non-profit disability group in Pennsylvania, are as follows:

Pennsylvania Protection and Advocacy is an organization designated by the Governor of Pennsylvania under the Developmentally Disabled Assistance and Bill of Rights Act of 1984, P.L. 98-527, 98 Stat. 2662, 42 U.S.C. § 6000 et seq., and the Protection and Advocacy for Mentally Ill Individuals Act of

1986, P.L. 99-319, 100 Stat. 478, 42 U.S.C. § 10801 et seq., to safeguard and advance the rights of persons with physical, developmental, and mental disabilities.

The Mental Health Association in Pennsylvania is a statewide organization that has, for the past thirty-five years, developed and mobilized broad-based citizen support for rights protection and improved care and treatment for adults and children who have mental illnesses.

The Pennsylvania Mental Health Consumers' Association is an organization of consumers of mental health services, including children, across the Commonwealth of Pennsylvania.

The Pennsylvania Coalition of Citizens with Disabilities is a statewide, cross-disability, consumer-directed and oriented organization devoted to the integration of all citizens with disabilities into the mainstream of life, and the development of comprehensive service systems to include all citizens.

The Developmental Disabilities Planning Council of the Commonwealth of Pennsylvania is a council federally-mandated under the Developmentally Disabled Assistance and Bill of Rights Act that addresses gaps in policy and service delivery for persons with developmental disabilities.

The Pennsylvania Association for Retarded Citizens is a statewide organization committed to creating full opportunities for persons with mental retardation.

The Pennsylvania Association for Children and Adults with Learning Disabilities is a statewide organization of parents and professionals dedicated to the attainment of appropriate human service programs for persons with disabilities.

The Association for Children and Adults With Learning Disabilities is a national organization dedicated to increasing the quality of life and expanding appropriate services for individuals with learning disabilities.

The Spina Bifida Coalition of Pennsylvania is a coalition of seven associations located throughout Pennsylvania that are dedicated to assisting individuals with spina bifida.

The Prader-Willi Syndrome Association of Pennsylvania is an organization dedicated to assisting persons with Prader-Willi Syndrome, along with their families.

The Pennsylvania Tourette Syndrome Association, an agency affiliated with the National Tourette Syndrome Association, was created to serve the needs of Pennsylvania citizens with Tourette Syndrome.

United Cerebral Palsy Association of Pennsylvania represents nineteen affiliate agencies throughout Pennsylvania that serve over 11,000 children and adults with disabilities annually and serves as an advocate for persons with disabilities throughout Pennsylvania.

The United Cerebral Palsy Association of Philadelphia & Vicinity is an organization that has served children with a diverse variety of disabling conditions for over forty years.

The American Council of the Blind Parents, part of the American Council of the Blind, is an organization dedicated to providing services and advocating for the needs of persons who are blind or visually impaired.

Pennsylvania Council of the Blind, an affiliate of the American Council of the Blind, is a chartered organization for the social and economic advancement of persons who are blind or visually impaired.

The ASAP Coalition of Autism Society of Pennsylvania is a coalition of local chapters of the Autism Society of America and of individuals that is designed to enhance the knowledge and strength of local chapters through statewide networking and to provide autism support and advocacy in Pennsylvania.

The Sickle Cell Genetic Disease Council of Southeastern Pennsylvania is an agency that advocates for persons who are affected with sickle cell anemia, along with their families.

Parents Involved Network is a parent-run network of parent groups across Pennsylvania that engage in self-help, advocacy, training, and education for parents of children and adolescents who have emotional or behavioral disorders.

Media Child Guidance is a community agency that provides outpatient mental health services and coordinates services for persons with mental retardation.

Erie Independence House is a community based organization that is managed and staffed by persons with disabilities for the purpose of assisting other persons with disabilities to attain and/or maintain their independence.

Millcreek and Erie County Advocates is a family and consumer organization that has ad-

vocated with and for Erie County citizens with disabilities for over sixteen years.

Down Syndrome Today is a support, advocacy, and resource group in Beaver County, Pennsylvania for persons with Down's Syndrome, their parents, and professionals.

ARGUMENT

THE SECRETARY HAS VIOLATED CONGRESS' MANDATE THAT CHILDREN WHOSE DISABILITIES ARE "OF COMPARABLE SEVERITY" TO THOSE OF DISABLED ADULTS RECEIVE SSI BENEFITS.

- I. The Secretary's Regulations Impose Far More Restrictive Standards For Determining Disability On Child Claimants Than On Adults.

In 1972, Congress enacted the Supplemental Security Income program, P.L. 92-603, 86 Stat. 1329 (1972), to provide one federally-coordinated benefits program for aged, blind, and disabled persons with limited incomes. As the House Report stressed, Congress was particularly concerned with the needs of poor, disabled children:

It is your committee's belief that disabled children who live in low-income households are among the most disadvantaged of all Americans and that they are deserving of special assistance in order to help them become self-supporting members of our society. H.R. Rep. 231, 92d Cong., 2d Sess. 1, 147-48, reprinted in 1972 U.S. Code. Cong. & Ad. News 4989, 5133-34.

For these reasons, Congress made the standard for determining disability in children the same as that for adults. The statute provides:

An individual shall be considered to be disabled for purposes of this subchapter if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity). 42 U.S.C. § 1382c(a)(3)(A) (emphases added).

Congress did not prescribe an exact method for determining when a child's disability is "of comparable severity" to that of a disabled adult, but, rather, empowered the

Secretary to establish regulations and procedures "not inconsistent" with the statute. 42 U.S.C. § 405(a), as made applicable to the SSI program by 42 U.S.C. § 1383(d)(1) (emphasis added).

However, the disability evaluation process for children that the Secretary has developed is flatly inconsistent with the statute and, in fact, results in the denial of SSI benefits to children with disabilities comparable to those of adults, thereby violating Congress' explicit mandate under the Social Security Act. See Mohasco Corp. v. Silver, 447 U.S. 807, 825 (1980) (agency's interpretation of statute as reflected in regulation "cannot supersede the language chosen by Congress").

To ascertain whether an adult claimant is disabled and therefore eligible for SSI (assuming satisfaction of the income requirements), the Secretary utilizes a comprehensive, two-tiered process. See generally Bowen v. Yuckert, 482 U.S. 137, 140-42 (1987). On

the first tier, the Secretary initially determines whether the adult is engaged in any substantial gainful activity. 20 C.F.R.

§ 416.920(a). If the adult claimant is not engaged in any substantial gainful activity, then the Secretary evaluates whether his or her impairment is "severe." 20 C.F.R.

§ 416.920(c).⁴ If it is, then the Secretary ascertains whether the adult's impairment meets or equals⁵ an impairment described in the Listings. 20 C.F.R. §§ 416.920(d), 416.926. If an adult claimant's impairment meets or equals one of the Listings, he or she is conclusively presumed to be disabled and is awarded SSI benefits. See id.; see also Yuckert, 482 U.S. at 141.

4. It is this second step, involving the so-called "severity regulation," and the Secretary's application thereof, that led to extensive litigation in the earlier part of this decade, culminating with this Court's decision in Bowen v. Yuckert, 482 U.S. 137 (1987).

5. The concept of equivalence is discussed infra at 34-35.

The Listings enumerate particular conditions, signs, and symptoms of certain impairments that, without any further evidence of impaired functioning capacity, justify a conclusion that the person is disabled. See 20 C.F.R. §§ 404.1520(d), 416.920(d), 416.925(a). Thus, they provide an administratively efficient method to shorten the evaluation process for SSI applicants who have impairments that are usually disabling. See Zebley, 855 F.2d at 773; see also Marcus v. Bowen, 696 F. Supp. 364, 373-76 (N.D. Ill. 1988) (providing a historical review of the Listings, and concluding that "they were never intended to be used as a basis for denial of disability benefits").

Recognizing that persons with non-"listed" impairments may nonetheless be disabled, the Secretary provides that adult claimants who do not meet or equal a particular Listing may still be eligible for SSI benefits. In such cases, the Secretary applies the next tier of the process -- an assessment

of the adult claimant's "residual functional capacity" ("RFC"). See 20 C.F.R. § 416.920(e). See also Heckler v. Campbell, 461 U.S. 458, 460 (1983); Yuckert, 482 U.S. at 141.

The RFC evaluation is an assessment designed to measure the actual degree of functional impairment of the individual based on, inter alia, descriptions, observations, and professional evaluations of conditions, signs, and symptoms other than those included in the Listings. 20 C.F.R. § 416.945(a). The RFC determination focuses primarily on the adult claimant's medical condition and, to a lesser extent, on the ability of the adult claimant to work. See Marcus, 696 F. Supp. at 381.

This two-tiered approach for determining disability in adults by which the Secretary considers both the Listings and the ability of an adult claimant to function stands in marked contrast to the process utilized for children. Disability in children is determined using only the first tier of the process used for adults, i.e., an assessment of whether the

child is engaged in substantial gainful activity, whether the child's impairments are severe, and whether the child's impairments meet or equal the requirements of one of the Listings. 20 C.F.R. § 416.924.

If the child's impairments are not among those included in the Listings, then he or she is automatically denied benefits -- regardless of the severity of the child's actual functional limitations resulting from single or multiple impairments, and regardless of any subjective factors. In short, the Secretary determines whether or not a child claimant is disabled without any individualized consideration of that child's actual ability to function.

As we will demonstrate in the next section, the result of the Secretary's process is that only a subgroup of children whose disabilities are comparable to those of adults are identified. Other disabled children, in blatant violation of the statutory mandate, are simply denied benefits.

II. The Abbreviated Evaluation Process
Accorded To Child Claimants Fails
To Identify Many Children Whose
Disabilities Are "Of Comparable
Severity" To Those Of Adults.

A. The Listings Are Inherently
Underinclusive.

The Secretary's single-tiered evaluation process for determining disability in child claimants fails to identify many disabled children who would be eligible for SSI if the Secretary applied the full two-tiered process used for adults. By providing for a two-tiered process for adults, the Secretary has recognized that the Listings are neither adequately flexible nor sufficiently comprehensive to identify SSI claimants who are disabled under the statutory standard. Indeed, the Secretary has expressly acknowledged that the Listings "are intended to identify the more commonly occurring impairments shown in applications for Social Security disability benefits," and that "[t]he Listing is but one item in the evaluation process." 44 Fed. Reg. 18175, 18176 (1979). As the court of appeals

in Zebley recognized, "[t]he listings . . . do not purport to be an exhaustive compilation of medical conditions which could impair functioning to the extent necessary to satisfy the statutory standard for [dis]ability." Zebley, 855 F.2d at 73. See generally H. Fox & A. Greaney, Disabled Children's Access to Supplemental Security Income and Medicaid Benefits, at 42-67 (December 1988) (hereinafter "Fox & Greaney").

In fact, the Listings are inherently underinclusive; no set of Listings could possibly be sufficiently comprehensive to encompass all disabling conditions. Moreover, the Listings do not -- and indeed cannot -- take into consideration the effect of multiple impairments, none of which alone meets or equals a listed impairment, but which in combination render a person functionally disabled. See 20 C.F.R. § 416.926. As illustrated by the cases described infra at 36-47, many children who have a combination of impairments and are significantly disabled are routinely denied SSI

benefits. The inability of the SSI child disability determination process to take into account the impact of multiple impairments has been consistently identified as one of the most troublesome aspects of the system. See Fox & Greaney, at 54 (noting that unpublished data from members of the American Academy of Pediatrics Committee on Children with Disabilities reveals that increasing numbers of children have complex medical conditions that involve as many as five or more different diagnoses). Additionally, the Listings do not reflect subjective aspects of an individual's impairment, such as pain, dizziness, or the effects of medication.⁶ The only suitable method by which such fundamental factors can

6. In fact, Social Security Administration policy affirmatively precludes consideration of subjective factors. See SSA Program Operation Manual System § DI 24501.025 ("[n]o alleged or reported intensity of the symptoms can be substituted to elevate impairment severity to equivalency") (emphasis deleted) (Jt. App. at 255).

be taken into account is through the use of a functional assessment.

By confining the analysis of children's disabilities to the Listings, the Secretary ensures that low-income children with multiple or unusual disabilities will be denied crucial income supplements. As one administrative law judge lamented in the case of Christine T., discussed infra at 37-38, where a child suffers from multiple impairments that fall "between the cracks" of the Listings, Social Security Administration policy precludes the granting SSI benefits.

B. The Listings Are Even More Under-
inclusive For Children Than They
Are For Adults.

In addition to the problems resulting from the inherent underinclusiveness of the Listings, the existing Listings violate 42 U.S.C. § 1382c(a)(3)(A) because they are in fact even more underinclusive for children than they are for adults, rendering it all the

more remarkable that they are the only avenue open to children to prove disability.

First, the Listings contain inadequate provisions for children who might be too young to be tested for various symptoms, but who are significantly disabled. See generally Fox & Greaney, at 54. For example, the section of the children's Listings governing deficits of musculoskeletal function requires that the child manifest either a need for assistance in ambulation, or an inability to feed and dress himself or herself. 20 C.F.R. Part 404, Subpart P, App. 1, Part B, § 101.03 (Jt. App. at 209-10). Certainly, an infant or young child cannot be tested in either of these areas. Similarly, Listings that require IQ tests or measurements of interference with communication, see, e.g., 20 C.F.R. Part 404, Subpart P, App. 1, Part B, § 111.02, § 111.07 (major motor seizures and cerebral palsy, respectively) (Jt. App. at 229, 230) are difficult, if not impossible, for infants or very young children to meet because such children

cannot realistically be tested in these areas. Thus, these children will be deemed ineligible for SSI.⁷

Second, the Listings completely omit certain childhood impairments, such as narcolepsy and other sleep disorders, spina bifida, Tourette Syndrome, Down's Syndrome, and Prader-Willi Syndrome.⁸ See Marcus, 696 F. Supp. at 381. A child who has one of these

7. In at least one Listing -- that for central visual acuity -- the Secretary has recognized that the Listing's test is inappropriate for children under six months of age and, in fact, has prohibited the test from being applied to such children. However, the Secretary has not provided any alternative method by which a young child can meet that Listing. See 20 C.F.R. Part 404, Subpart P, App. 1, Part B, § 102.00A, § 102.02 (Jt. App. at 210-11).

8. Tourette Syndrome is characterized by motor incoordination, involuntary word repetition, and involuntary utterance of vulgar or obscene words. Down's Syndrome is a chromosomal disorder that results in mental retardation and a constellation of physical anomalies. Prader-Willi Syndrome is a congenital syndrome characterized by short stature, mental retardation, excessive eating, marked

(Footnote continued)

impairments will be denied benefits unless the child's impairment can somehow be made to fit within an existing Listing.

In addition, many of the adult Listings (which are to be used in the absence of an analogous Listing for children, see 20 C.F.R. § 416.925(b)(1)) are incapable of being applied to children. For example, the adult Listing for obesity contains height and weight charts beginning at sixty inches tall for men and fifty-six inches tall for women. 20 C.F.R. Part 404, Subpart P, App. 1, Part A, § 10.10 (Jt. App. at 169-73). Because there is neither a corresponding children's Listing for obesity nor a corresponding table for a child's lower height (not to mention a child's different build), a young child who is obese

(Footnote continued)

obesity, and sexual infantilism. See Stedman's Medical Dictionary (5th ed. 1982).

will simply be denied benefits. See also 20 C.F.R. Part 404, Subpart P, App. 1, Part A, § 8.00 (all skin disorders) (Jt. App. at 166-67); § 11.09 (multiple sclerosis) (Jt. App. at 178); § 11.13 (muscular dystrophy) (Jt. App. at 178) (see discussion of the case of Jason E., infra at 44-46); § 11.16 (pernicious anemia) (Jt. App. at 179).

C. An Evaluation Of The Functional Capacity Of Child Claimants Is Essential.

The inherent inadequacies of the Listings can be remedied, as they are for adults, by employing an evaluation of the child's functional impairment. See Yuckert, 482 U.S. at 146 (Social Security Act requires a "functional approach to determining the effects of medical impairments"); see also 42 U.S.C. § 1382c(a)(3)(G) (emphasis added) ("the Secretary shall consider the combined effect of all the individual's impairments").

At the outset of the SSI program for children, the Secretary recognized the impor-

tance of assessments based on functional factors, rather than on Listings alone. He emphasized that "disability in children must be defined in terms of the primary activity in which they engage, namely growth and development, the process of maturation," and that "[d]escriptions of a child's activities, behavioral adjustment, and school achievement [are] important in determining the severity of the impairment." SSA Disability Insurance Letter No. III-11 (Jt. App. at 90-91).

Nevertheless, as explained in Fox and Greaney's recent report on disabled children's access to SSI, the absence of regulations permitting the Social Security Administration to assess a child claimant's functional capacity has resulted in the unavailability of SSI benefits to many disabled children:

The majority of our expert reviewers indicated their concern about the Listing's lack of attention to functional impairment. They stressed that the same medically defined condition may affect different children in different ways: for some children, a less serious condition may render them functionally incapacit-

ated. . . . The impact of a given impairment on a child's ability to carry out daily activities is dictated by a variety of factors. These include age of onset, emotional and cognitive capacities, and family support and resources -- none of which are addressed in the disability criteria for children. Fox & Greaney, at 60-61.

The Secretary has an obligation to develop a standard by which to measure the ability of a child to function. That measurement should include, at minimum, a determination of whether the child can carry out daily activities on an age-appropriate level. Such a functional analysis, as anticipated by the Court in Zebley, would be based upon medical findings. An assessment of functional capacity would also take into account, inter alia, subjective factors and combinations of impairments and, thus, would cure the existing inherent defects of the Listings-based approach currently used to assess disability in child claimants.

While the Secretary has expressed concerns about the feasibility of engaging in an

individualized assessment of a child's functioning, those concerns are ill-founded, if not disingenuous. First, it is the Secretary's statutory responsibility to determine disability. Even if such individualized, functional assessments were more difficult to make, this factor would not relieve him of that obligation. Moreover, the agency has had ample experience in engaging in the precise type of individualized assessment required.⁹

In addition, the Secretary has recently proposed new Listings for Mental Disorders in

9. Under the Title II Child's Disability Insurance Benefit Program, 42 U.S.C. § 402(d), the Secretary applies the full two-tiered evaluation process to assess disability in a dependent person who is claiming benefits based on an impairment that was disabling before the age of 22. See Allegra v. Bowen, 670 F. Supp. 465 (E.D.N.Y. 1987); Hawkins v. Heckler, 631 F. Supp. 711 (D.N.J. 1985). Indeed, the Secretary has previously acknowledged that experience drawn from the Title II Disability Program would assist in the implementation of the SSI program. See SSA Disability Insurance Letter No. III-11 (Jt. App. at 89).

Children, see 54 Fed. Reg. 33238 (August 14, 1989), which, in fact, incorporate some of the very same functional criteria that the Secretary has previously asserted are either irrelevant to a determination of whether a child is disabled or overly-cumbersome to apply. Compare Sullivan v. Zebley, Brief for the Petitioner, at 40 (citations omitted) ("developmental needs - e.g., counseling, special education, training, rehabilitation, and guidance - are not considered as such, 'because they are not within the scope of the law'") with 54 Fed. Reg. at 33243 ("school records are a rich source of data;" "appropriate historical, social, medical and other information must be reviewed").

At the very least, the Secretary's inclusion of functional evidence in the proposed Listings for mental disorders indicates a fundamental inconsistency in his position. There is certainly no rational reason why children with mental disorders should receive a func-

tional assessment of their disability while children with other impairments do not. It is no less feasible to analyze the functional limitations of children with physical, rather than mental, disorders. Thus, an evaluation of the functional capacity of child claimants not only is statutorily mandated, but also, by the Secretary's own admission, is administratively feasible.¹⁰

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10. It should also be noted that, even though some of the proposed regulations may apply a function-based evaluation, that analysis is still much more restrictive than that applied to adults. Many of the proposed Listings require that functional limitations be evaluated solely within the parameters of each individual Listing. Thus, once a child has proven that he or she meets the medical criteria for one of the impairments, he or she must also demonstrate that that impairment results in functional limitations. See, e.g., Proposed Listing 112.00, 54 Fed. Reg. at 33241 ("The functional restrictions ... must be the result of the mental disorder which is manifested in the clinical findings"). See also Proposed Listings 112.02, 112.03, 112.04, 112.06, 112.07 and 112.09, 54 Fed. Reg. at 33243-33245.

D. The Secretary Has Failed To Devise Any Method To Assess Adequately The Functional Capacity of Child Claimants.

None of the means devised by the Secretary provides a satisfactory method by which to ensure that there is an individual analysis of the ability of disabled children to function in an age-appropriate manner. In the past, the Secretary expressly acknowledged that the Listings are underinclusive as applied to children, stressing that:

Not all children's impairments will lend themselves to formal codification. We are aware that a significant number of children are impaired in their intellectual, social, and emotional development progression by problems of learning and/or behavior. These conditions may be ill-defined and imperfectly understood. 1974 Disability Insurance Letter No. III-11, Supplement 1 (Jt. App. at 97-98).

Although a few of the Listings define impairments in functional terms, a point the

Secretary now understandably emphasizes,¹¹ the Listings generally rely on specific diagnostic criteria that exclude clinically observable functional indicia that the medical profession commonly includes in its assessments of disabilities. See 42 Fed. Reg. 14705 (1977) (childhood Listings "interpret[] severity in medical rather than functional terms.").

Moreover, the Secretary expressly prohibits the decisionmaker from taking the child claimant's level of functional limitation into account in determining whether the child's impairment "meets" a Listing. As the Secretary has directed:

The "level of severity" of impairments in the listing is not defined

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11. The Secretary, however, conceded in his certiorari petition that only "some of the Secretary's listings in Part B specifically call for a general assessment of a child's functional capacity." Newman v. Zebley, Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit, at 12 (emphasis added).

in terms of the residual functional capacity (RFC) of the individual. When certain functional limitations are specified for a listed impairment, they relate only to that degree of dysfunction for that particular listing section and only to the specific function identified. SSA, Program Operations Manual System (POMS), § DI 24505.015(B) (emphasis in original) (Jt. App. at 248).

As a so-called alternative to meeting a listed impairment, an SSI applicant may establish that his or her impairment "equals" a listed impairment. 20 C.F.R. § 416.920(d); § 416.924(b). Because the Secretary's definition of equivalence is extremely narrow, the equivalence standard, like the Listings themselves, is incapable of identifying many children whose impairments are of comparable severity to those of adults.

Equivalence to a listed impairment is based strictly on a very narrow notion of medical findings that is void of functional criteria. 20 C.F.R. § 416.926(b). Indeed, since 1980 the Secretary has expressly proscribed consideration of the functional consequences of impairments in determining equiva-

lence. See Social Security Ruling (SSR) 83-19 ("[t]he functional consequences of the impairments, (i.e., RFC), irrespective of their nature or extent, cannot justify a determination of equivalence") (emphasis in original) (Jt. App. at 240); see also Zebley, 855 F.2d at 74. In addition, the equivalence standard does not allow for consideration of the combined effect of impairments. See SSR 83-19 ("[t]he mere accumulation of a number of impairments . . . will not establish medical equivalence.") (Jt. App. at 240).¹²

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12. Amici are of the opinion that the Secretary's children's disability regulations violate the provisions of the Disability Benefits Reform Act of 1984, P.L. 98-460, 98 Stat. 1794, which requires that the Secretary consider the "combined effect" of all of a claimant's impairments, 42 U.S.C. § 1382c(a)(3)(G), as well as "all evidence" in the claimant's case record, 42 U.S.C. § 1382c(a)(3)(H). We agree with the court of appeals that these requirements would be satisfied if the Secretary were to comply with the statutory mandate and perform functional, individualized assessments of children comparable to those performed for adults. Zebley, 855 F.2d at 76.

E. Numerous Severely Disabled Children Have Been And Will Continue To Be Denied SSI Benefits Due To The Secretary's Refusal To Assess Their Functional Capacity.

The Secretary's process for determining disability in children works significant hardships on impoverished children with disabilities who must often go without needed medical and social services when their SSI applications are denied.¹³ The following examples are representative of children in Pennsylvania whose SSI claims have been rejected by the Secretary based upon his conclusion that such children are not disabled within the meaning of the statute.

13. Under Pennsylvania law, eligibility for Medicaid is tied to SSI eligibility. See 55 Pa. Code § 297.4(w)(4). Thus, the implications of the SSI determination are far-reaching and the financial consequences of being found ineligible for SSI can be devastating.

-- Christine T. was five years old at the time she was found not eligible for SSI. Christine has been diagnosed as severely hyperactive with a guarded prognosis. She also has an attention deficit disorder, an expressive speech delay, delayed fine motor-adaptive skills, and a very short attention span. Although placed on an unusually high dose of medication, Christine continues to manifest unmanageable, disruptive, impulsive, and hyperactive behavior. For example, during the administrative hearing, Christine left her chair, climbed underneath an examination table, constantly moved about the room, and even triggered a fire alarm outside of the room.

The Administrative Law Judge ("ALJ") determined that Christine has a behavioral problem, a behavioral communication disorder, and is extremely hyperactive. However, because she does not have either a specific psychiatric disorder or an organic disability, her impairments were deemed not to meet or equal any of the Listings. The ALJ also noted that

an impartial medical advisor at the administrative hearing testified that Christine's disorder fell "between the cracks" of the Listings, and that Social Security Administration policy precluded him from considering any criteria other than those actually detailed in the Listings.

-- Michael R. was six years old at the time he was denied SSI benefits. Michael has had a life-long history of severe neurological and emotional impairments. Michael has been diagnosed as having, among other impairments, organic brain syndrome, a seizure disorder, a learning disability, attention deficit disorder/hyperactivity, multiple personality disorder, mental retardation, and impulse control disorder.

Michael's impairments have profoundly and adversely affected his education; indeed, his teachers have noted that his temper tantrums, impulsive and explosive behavior, and inability to follow directions are incompatible with an educational setting. Furthermore,

Michael has been diagnosed as functioning at the level of a three to four year old and, consistent with this diagnosis, has repeatedly demonstrated non-age-appropriate behaviors. For example, Michael is not capable of dressing himself or brushing his teeth and does not interact with children his own age. Additionally, Michael has devastating psychological problems that manifest themselves in ways ranging from fighting with others to hearing voices telling him to harm himself and others to overtly suicidal behavior such as climbing out on a window ledge, tying a sheet around his neck, and trying to cut himself with a knife. In fact, at one point Michael's behavior became so uncontrollable that he was hospitalized at the Eastern Pennsylvania Psychiatric Institute.

The ALJ concluded that Michael's impairments, "while severe", did not meet or equal a Listing. The ALJ determined that although Michael had an IQ of 64, he had no other phys-

ical or mental impairment sufficient to meet or equal the Listing for mental retardation.

-- Dean O. was two years old at the time he was found ineligible for SSI benefits. Dean has a breathing problem, spina bifida, conjunctivitis of the eyes, digestive problems, chronic nonspecific diarrhea, a learning disability, anemia, hyperactivity, and developmental delay. Additionally, Dean suffers from a sensory integrative dysfunction which includes delayed speech, clumsiness, tactile defensiveness, and distractibility. Dean's breathing problem, which he has had since birth, has included one episode of apnea, for which a monitor was prescribed. In addition, Dean has been hospitalized on numerous occasions, once at six weeks of age for pneumonia, and on several other occasions for episodes of dehydration accompanied by vomiting and diarrhea. Furthermore, Dean has been described as a destructive child who bites himself and goes after knives. The ALJ concluded that, while Dean has physical problems, as well as mental

and motor delay, those impairments did not meet or equal a Listing.

-- Henry R. was eleven years old at the time he was found ineligible for SSI benefits. Henry has oppositional disorder, attention deficit disorder, visual-motor and perceptual dysfunctions, and hyperactivity. His visual-motor coordination is so poor that, at almost eleven years of age, his ability to draw geometrical designs was at the level of a five year old. Henry's IQ test scores have varied between 49 and 78. He has marked difficulties in maintaining social functioning, deficiencies in concentration, extremely low frustration tolerance, and is emotionally withdrawn. He is an intentionally provocative, passive-aggressive, angry, and highly distractible child, who gets into fights with his peers and siblings.

As a result of the variation in Henry's IQ scores, the ALJ concluded that Henry did not meet the listed impairment for mental retardation. In particular, the ALJ deter-

mined that the lower IQ scores did not accurately reflect Henry's IQ because Henry's behavioral problems, such as his passive/aggressive attitude, poor attention, and nervousness, interfered with the testing. However, the ALJ discounted evidence that Henry's behavioral problems imposed an additional limitation on him that would meet or equal a Listing and concluded that Henry's lack of attention was selective and voluntary and that his nervousness could be treated with medication.

-- Shawn K. was ten years old when he was found ineligible for SSI benefits. Shawn is a child with borderline intelligence, attention deficit disorder, hyperactivity, psycholinguistic deficit, delay in visual-motor coordination, and chronic enuresis (bedwetting). Shawn's IQ scores range from a low of 70 to a high of 92. Shawn has been placed in a special education classroom, attends speech therapy classes, and requires intensive instruction in fine motor skills.

Shawn's teachers report that his behavior in the special education classroom is unsatisfactory, and that he is disruptive and inattentive. Shawn needs much one-on-one supervision due to his short attention and memory spans and his problems following directions. Shawn's hyperactivity has not been controlled by medication; he is constantly running and jumping, cannot sit still, and is extremely impulsive. Furthermore, Shawn is fascinated by fire and has been known to set fires. For example, when Shawn was playing with a fire truck in his bedroom, he decided that he needed a fire, and so he set one, destroying all of his belongings.

The ALJ determined that Shawn did not meet the Listing for mental retardation because his IQ of 70 was one point above that required by those Listings. Although a Medical Advisor had testified that the one point differential was neither meaningful nor significant, and that the only reason Shawn would not meet the Listing was due to a technicali-

ty, the ALJ considered himself bound by the letter of the Listings. Therefore, the ALJ did not even consider Shawn's attention deficit disorder, hyperactivity, poor attention span, bedwetting, or other problems.

-- Jason E. was five years old when he was found ineligible for SSI benefits. Jason has muscular dystrophy, a progressively degenerative and eventually fatal muscular disease. At the time he was denied benefits, Jason's impairment manifested itself through a speech disturbance, moderate muscle weakness, gait abnormality, decreased muscle tone, atrophy of the proximal muscles, and hypertrophy. Jason's eye muscles and mouth and vocal chord muscles were also affected by his impairment. Furthermore, Jason experienced difficulty in walking because of cramps and weakness in his legs. At the time he was denied benefits, Jason could not climb stairs, run, pedal a bicycle, or walk in excess of a city block, and he frequently fell. Moreover, Jason could

not control a pencil or endure a full day in kindergarten due to exhaustion.

There is no children's Listing for muscular dystrophy. The ALJ therefore applied the Listing for deformity or musculoskeletal disease, which requires both deformity or musculoskeletal disease and one of the following: (a) "walking is markedly reduced in speed or distance despite orthotic or prosthetic devices"; (b) "ambulation is possible only with obligatory bilateral upper limb assistance (e.g., with walker, crutches)"; or (c) "inability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene." 20 C.F.R. Part 404, Subpart P, App. 1, Part B, § 101.03 (Jt. App. at 209). Applying these criteria to Jason, the ALJ determined that Jason could walk in an unassisted fashion for at least short distances, thereby failing to meet the requirements of § 101.03(A); that he did not yet require any assistive devices for ambulation (although it was clear that he would require

them), thereby failing to meet the requirements of § 101.03(B); and that he was basically independent in self-care activities, thereby failing to meet the requirements of § 101.03(C).

-- Jason S. was six months old when he was initially found not eligible for SSI, and a year old when his second SSI application was denied. Jason has spina bifida, a birth defect affecting the lower portion of his spine, which impairs his ability to walk, as well as his bowel and bladder functions. Additionally, Jason's vocal chords are paralyzed, which creates overwhelming problems for him in swallowing, breathing, and speaking. He also has Arnold Chiari malformation, a displacement of the hind brain into his spinal canal.

-- Brandi R., who is now twelve years old, has Tourette Syndrome, a neurological movement disorder, was also denied SSI benefits. As a result of her impairment, Brandi experiences motor control problems, a severe

attention deficit disorder, and behavioral disorders.

* * *

These and other exclusions of seriously disabled children from benefits of the SSI program are inevitable under the current regulations. The Secretary's truncated, Listings-confined approach by definition prevents a substantial number of low-income children with significant functional disabilities from receiving the benefits that Congress intended them to have.

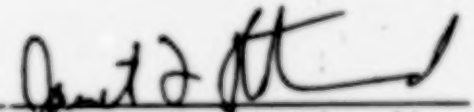
CONCLUSION

The single-tiered, Listings-confined process that the Secretary utilizes to determine whether a low-income child is disabled for purposes of eligibility for SSI benefits violates the mandate of Congress. The Secretary's regulations deny children the same opportunity afforded adults to demonstrate the disabling functional effects of their

impairments. Accordingly, Amici Curiae respectfully urge the Court to affirm the order of the court of appeals.

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**In the
Supreme Court of the United States.**

OCTOBER TERM, 1989.

LOUIS W. SULLIVAN, SECRETARY
OF HEALTH AND HUMAN SERVICES,
PETITIONER,

v.

BRIAN ZEBLEY, ET AL.,
RESPONDENTS.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE THIRD CIRCUIT.

**Brief of the Commonwealths of Massachusetts
and Pennsylvania, the States of Alabama, Alaska,
Arizona, Arkansas, Connecticut, Delaware, Illinois,
Indiana, Iowa, Kansas, Louisiana, Maryland, Minnesota,
Missouri, Montana, Nebraska, New Hampshire,
New York, Rhode Island, South Dakota, Tennessee,
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No. 88-1377

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1989

Louis W. Sullivan, Secretary
of Health and Human Services,
Petitioner,

v.

Brian Zebley, et al.,
Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF OF THE COMMONWEALTHS OF
MASSACHUSETTS AND PENNSYLVANIA,
THE STATES OF ALABAMA, ALASKA, ARIZONA,
ARKANSAS, CONNECTICUT, DELAWARE,
ILLINOIS, INDIANA, IOWA, KANSAS,
LOUISIANA, MARYLAND, MINNESOTA, MISSOURI,
MONTANA, NEBRASKA, NEW HAMPSHIRE,
NEW YORK, RHODE ISLAND, SOUTH DAKOTA,
TENNESSEE, TEXAS, UTAH, VERMONT AND
WYOMING, AND THE DISTRICT OF COLUMBIA,
AMICI CURIAE IN SUPPORT OF RESPONDENTS

INTEREST OF AMICI CURIAE

Amici curiae submit this brief in
support of respondents. Amici urge this

Court to affirm the judgment below, which invalidated the Social Security Administration's ("SSA's") policy regarding eligibility of disabled children for Supplemental Security Income ("SSI") benefits.

As this Court has recognized, each state has a "quasi-sovereign interest in the health and well-being - both physical and economic - of its residents in general." Alfred L. Snapp & Son, Inc. v. Puerto Rico, 458 U.S. 592, 607 (1982). Where the interests of children are concerned, the states' interest is particularly strong; indeed, "[t]here is no more worthy object of the public's concern" than protection and aid for dependent children. Wyman v. James, 400 U.S. 309, 318 (1971).

The states' interest in the welfare of their children is most acute with respect to those whose needs are greatest, and whose families are least able to provide for them, so that they are most dependent on the benefits provided by the various levels of government. As Congress expressly recognized in enacting the Social Security Amendments of 1972, children who are both poor and disabled, and the families of such children, are among the neediest and most disadvantaged. H.R. Rep. No. 231, 92nd Cong., 2nd Sess., reprinted in 1972 U.S. Code Cong. & Ad. News 4989, 5133-34. Amici therefore have a strong interest in these children's access to the benefits granted them by federal statute.

In addition to their concern for the welfare of their citizens, the states

have a strong interest in protecting themselves from undue fiscal burdens. Because of their commitment to the welfare of their neediest citizens, the states operate various partially or wholly state-funded health and welfare programs, to which applicants rejected from federally-funded programs may turn for assistance. To the extent that these state-funded programs fill a gap in federal coverage caused by unlawful rejections, the federal administrative policies that cause those rejections have the effect of shifting costs from the federal level to the states.^{1/}

^{1/} The policy challenged in this case may be seen as part of a larger effort to shift costs of welfare programs from the federal government to the states. Although some of these efforts have been upheld, see, e.g., Lukhard v. Reed, 481 U.S. 368 (1987) (plurality) (upholding

(footnote continued)

Such cost-shifting subverts the will of Congress, to the detriment of both the states themselves and their neediest citizens. Amici have strong interests

(footnote continued)

restrictive application of statutory change in income standard for Aid to Families with Dependent Children); Lyng v. Castillo, 477 U.S. 635 (1986) (upholding statutory change restricting Food Stamp eligibility), many have been overturned, either by court decision or by legislative enactment. See, e.g., DeLeon v. Secretary of Health and Human Services, 734 F.2d 930 (2d Cir. 1984) and cases cited at 937 (restricting or invalidating Social Security Administration's Continuing Disability Review program); Act of Sept. 19, 1984, Pub.L. No. 98-460; 1984 U.S. Code Cong. & Ad. News 3046-62 (restricting Continuing Disability Review program and mandating alteration in other Social Security Administration policies). In order to defend themselves against the fiscal impact of such cost-shifting, several states have found it cost-effective to fund programs of legal assistance for persons claiming eligibility for certain federal benefits, e.g., Mass. St. 1989, c. 240, § 2, items 0321-1600 and 0321-2000, allocating funds for that purpose.

in correcting such erroneous administrative policies.

In this case, SSA has adopted an approach to determining disability in children that is so rigid and restrictive as to exclude many children who are severely disabled. The consequences of this policy are devastating to those children and their families, and harmful to the states' interests as well. Amici therefore urge this Court to affirm the judgment below, which invalidated SSA's policy and enjoined its further application.

SUMMARY OF ARGUMENT

I. In enacting the SSI statute, Congress intended to relieve the states of the fiscal burden of caring for the disabled, and to assume that burden at

the federal level. Congress included low-income disabled children in the SSI program in order to provide for the special costs of their care, and to ensure that those costs would not fall to the states (pp. 10 to 14).

By applying an overly restrictive standard for disability determinations for children, SSA has excluded from the SSI program low-income children suffering from severe disabilities. In this manner, SSA has shifted to the states certain costs of the care of such children, and has thereby thwarted the will of Congress (pp. 14 to 16).

Children who are erroneously denied SSI benefits and associated Medicaid coverage often fall back on Aid to Families with Dependent Children ("AFDC"),

or state-funded general assistance and medical assistance programs. Such erroneous denials thus increase the costs of these programs to the states. In addition, such children may receive assistance from various specialized, state-funded health and human services programs, thereby draining the resources that would otherwise be available through those programs for services to others. State and local governments may also bear the costs of health care for such children through subsidies to public hospitals or to private hospital uncompensated care programs. Disabled children who do not receive care may suffer increased life-long dependency on publicly-funded services with consequent costs to the states (pp. 16 to 31).

II. The Court of Appeals correctly ruled that SSA's regulations reflect an erroneous interpretation of the governing statute, and are therefore invalid. In evaluating SSA's policy, the Court need not defer to the agency's interpretation, because congressional intent can be determined through traditional tools of statutory construction. Since SSA's regulations conflict with congressional intent as so determined, they must fall (pp. 31 to 34).

The process of statutory construction must begin with the plain meaning of the statutory terms. Here, the plain terms of the governing statute require that eligibility standards include each child who suffers from any impairment or combination of impairments of comparable

severity to those that would disable an adult. In violation of this statutory requirement, SSA limits eligibility to those children whose impairments meet or equal its listing of impairments, without providing for any individual determination of the functional effects of each child's impairment or combination of impairments. SSA's policy thus conflicts with the plain terms of the statute (pp. 34 to 37).

ARGUMENT

- I. THE SOCIAL SECURITY ADMINISTRATION'S UNDULY RESTRICTIVE APPROACH TO SSI ELIGIBILITY DETERMINATIONS FOR CHILDREN SHIFTS TO THE STATES COSTS THAT CONGRESS HAS DECIDED SHOULD BE BORNE AT THE FEDERAL LEVEL.

The SSI program, 42 U.S.C. §§ 1381-1383c (1982), was established by Congress in 1972, to replace earlier state-

administered programs of aid to the elderly, blind and disabled. See Schweiker v. Gray Panthers, 453 U.S. 34, 38 (1981). In replacing state programs with an entirely federally-funded program, Congress indicated its intention to relieve the states of the costs of providing such aid, and assumed that cost at the federal level.

Fiscal relief to the states was no accidental effect of the statute; rather, one of Congress's expressly stated purposes was "to relieve state and local governments of the soaring costs" of existing programs for the disabled. City of New York v. Heckler, 578 F.Supp. 1109, 1121 (E.D. N.Y.), aff'd, 742 F.2d 729 (2d Cir. 1984), aff'd sub nom., Bowen v. City of New York, 476 U.S. 467 (1986), citing legis-

lative history of the 1972 Act. See also Dixon v. Heckler, 589 F.Supp. 1512, 1516 (S.D.N.Y. 1984); Holden v. Heckler, 584 F.Supp. 463, 467, 486 (N.D. Oh.), remanded, 754 F.2d 372 (6th Cir. 1984); Avery v. Heckler, 584 F.Supp. 312, 316 (D. Mass. 1984), aff'd, 762 F.2d 158 (1st Cir. 1985).

As established by Congress, the SSI program provides financial assistance not only to adults disabled from substantial gainful employment, but also to disabled children who live in households with very low income. Congress included low-income disabled children in the SSI program, although they had not been included in earlier disability programs, in recognition of the extraordinarily high cost of their daily care. H.R. Rep. No. 231, 92nd Cong., 2d Sess., re-

printed in 1972 U.S. Code Cong. & Ad. News 4989, 5133-34. For the low-income family of a disabled child, SSI cash benefits can meet the otherwise prohibitive costs of specialized day care, skilled home care, rehabilitation programs, special equipment, and other essential goods and services necessitated by the child's condition.

In addition to cash assistance for such purposes, and even more crucial for many families, SSI coverage in the overwhelming majority of states conveys automatic eligibility for Medicaid, assuring the disabled child's access to urgently needed health care. See 42 U.S.C. § 1396a(a)(10)(A)(i)(II) (1982); see also United States Department of Health and Human Services, Characteristics of State Assistance Pro-

grams for SSI Recipients, (1989), p. 110. For low-income families of children who require frequent and costly medical treatment, the importance of such coverage cannot be overstated. Even the rare low-income family that has access to private health insurance, through employment or otherwise, may depend heavily on SSI-based Medicaid coverage to ensure a disabled child's access to medical care; insurance may leave a significant portion of charges uncovered, may exclude necessary specialized services, or may even exclude the child entirely because of his or her condition.

Despite Congress's expressed intention to guarantee SSI benefits for disabled children, and thereby to relieve

the states of the costs of their care, SSA has adopted a rigid, restrictive approach to eligibility determinations for children that effectively excludes many whose conditions do in fact disable them severely. Although the statute by its terms requires comparable treatment of adults and children in disability determinations, 42 U.S.C. § 1382c(a)(3)(A) (1982), SSA subjects children to a more restrictive standard than adults, requiring only children to demonstrate medical findings that meet or equal those included in its listings of presumptively disabling conditions, and providing no mechanism for evaluating the combined effect of multiple impairing conditions on children.

As a result, large numbers of children whose impairments are comparable to ones that would disable adults from substantial gainful employment are denied SSI benefits, in contravention of the statute. Many of these low-income, disabled children and their families turn to state programs for assistance with the financial burdens arising from their impairments. Thus, through its administrative policy, SSA has circumvented Congress's intention to assume these burdens at the federal level, and has shifted them to the states.

A. Welfare Programs.

1. Aid to Families With Dependent Children.

Erroneous denials of SSI benefits to disabled children impose a wide variety

of direct and indirect burdens on state budgets. The most direct costs appear in welfare programs partially or wholly funded by the states.

Many children who are financially eligible for SSI are members of families who also qualify for Aid to Families with Dependent Children ("AFDC"). See, e.g., "Survey of Disabled Children Under SSI Program", Social Security Bulletin, January, 1980, Vol. 43, No. 1, p. 10.^{2/} Approximately half of the funding for AFDC benefits comes from the state. 42 U.S.C. § 603 (1982).

^{2/} The proportion of SSI eligible families who also qualify for AFDC varies from state to state, because AFDC financial eligibility criteria vary among the states, while SSI financial eligibility is uniform nationwide. 42 U.S.C. §§ 602 (a)(7), 1382 (1982).

The amount paid to a family on AFDC depends on the number of persons in the AFDC assistance unit. Since a child receiving SSI is automatically excluded from the assistance unit, that child's SSI eligibility reduces the size of the unit for AFDC purposes, and consequently reduces the financial burden on the state. 42 U.S.C. § 602(a)(24) (1982).^{3/} Conversely, if the child is erroneously excluded from SSI, and

3/ For example, an AFDC-eligible family with two children would be treated for AFDC purposes as a family with one child if the second child were on SSI. The family would receive the child's SSI benefit, plus an AFDC grant for the other family members. If the second child were denied SSI benefits, however, the family would be treated as having two children and would receive a higher AFDC grant. The increased AFDC grant would not be enough to offset the lost SS. benefit, so both the family and the state would suffer an economic loss.

therefore remains in the AFDC unit, the state's AFDC burden is higher than it would be otherwise be. For the family, however, the denial of SSI coverage outweighs the additional AFDC benefit, since SSI payments are uniformly higher than the incremental AFDC payment for an additional family member.^{4/}

4/ In states that supplement SSI payments and that include children among those eligible for such supplements, the cost of AFDC benefits for these children may be at least partially offset by reduced SSI supplements. The fiscal impact on states of such offsets varies widely because of the greatly varying size of, and eligibility requirements for, supplements paid by the states. See United States Dept. of Health and Human Services, Characteristics of State Assistance Programs for SSI Recipients (1989).

2. General Assistance.

Many states also operate general assistance programs that provide both cash benefits and medical assistance to low-income families not eligible for AFDC. E.g., Md. Ann. Code Art. 88A, §§ 65A, 65B; Mass. Gen. Laws ch. 117, §§ 1-25 (1986); Mass. Admin. Code Tit. 106, § 312 (1988).^{5/} These programs are operated and funded completely by the states and local governments, with no

^{5/} As of 1983, at least forty-two states had general assistance programs and at least thirty-four states had medical assistance programs for which children wrongfully denied SSI could qualify. Urban Systems Research and Engineering, Inc., Characteristics of General Assistance Programs 1982 (U.S. Department of Commerce, National Technical Information Service, 1983).

federal contribution to either the cash benefit or the medical assistance.

In states that do not participate in the AFDC-Unemployed Parent ("AFDC-UP") program, see 42 U.S.C. § 607 (1982), general assistance may be the only welfare program available to children in two-parent families.^{6/} Even in states that do have the AFDC-UP program, some families who do not meet the particular requirements of that program may be eligible for general assistance, medical

^{6/} As of 1988, twenty-eight states and other jurisdictions operated AFDC-UP programs; twenty-six did not. United States Department of Health and Human Services, Characteristics of State Plans for AFDC (1988). A modified form of the AFDC-UP program will become mandatory for all jurisdictions as of October 1, 1990. 42 U.S.C. § 607(b), as amended by Act of Oct. 13, 1988, Pub. L. 100-485, Title IV, and Act of Nov. 10, 1988, Pub. L. 100-647, Title VIII.

assistance, or both. See generally Batterton v. Francis, 432 U.S. 416 (1977).

SSI coverage for a disabled child reduces general assistance payments to the child's family by decreasing the amount of general assistance for which the family is eligible. Conversely, improper denials of SSI coverage increase the burdens on general assistance programs, to the states' fiscal detriment.^{7/} In states not adopting the Medicaid-Under 21 program, 42 U.S.C. § 1396a(a)(10)(A)(ii) (1982), any medical benefits to these children

^{7/} For example, the Massachusetts Department of Public Welfare noted dramatic increases in the number of incapacitated adults receiving General Relief during the years 1981-1983, when the Social Security Administration implemented a nationwide program of reviewing earlier SSI disability determinations.

also are funded solely by the states; those states thus suffer an even greater fiscal drain from improper denials of SSI.^{8/}

B. Specialized State-Funded Health Care Programs.

In addition to AFDC and general assistance programs, a wide variety of state-funded health and human service programs bear increased burdens when children are erroneously excluded from

^{8/} Improper denials of SSI eligibility to children increase the states' AFDC and general assistance burdens through an additional, less direct mechanism. Without funds for the purchase of services, a disabled child's need for constant, specialized care may prevent a parent from working, thus rendering the entire family dependent on state-funded benefits. For many such families, SSI benefits could make employment -- and economic independence -- possible by funding alternative care for the disabled child.

SSI. In Massachusetts, for example, three programs sponsored by the Department of Public Health ("DPH"), funded solely by the Commonwealth, provide limited quantities of goods or services to children with special medical needs.

The "Home Health Care" program provides intermittent at-home assistance in the care of multiply handicapped children, particularly after surgery or at times of emergency, thus promoting the ability of families to care for their children at home. The "Early Intervention" program provides a variety of specialized rehabilitative therapies, to promote maximum long-term development of children with developmental delay. Under the "Special Medical Needs" program, DPH has provided chronically ill

or physically impaired children with one-time grants of up to five thousand dollars for medical procedures or rehabilitative equipment.

Funds for these and similar programs are limited, however, and services are provided only subject to availability of funds. To the extent that families can use SSI benefits to purchase these services, or that Medicaid reimbursement is available as a result of SSI eligibility, limited state resources can be used for services to other equally needy persons. Conversely, for disabled children who are erroneously denied SSI benefits, such limited state-funded programs may be the only alternative.^{2/}

^{2/} Similarly, state-funded mental health and mental retardation services, respite care, case management, and

(footnote continued)

C. Other Health Care Costs.

Even when disabled children who are erroneously rejected from SSI and corresponding Medicaid coverage do not participate in state-funded programs, the costs of whatever health care they receive ultimately falls, at least in part, upon state and local governments. Children who lack adequate health insurance or Medicaid coverage often rely on public hospitals, which are supported by states and local governments. Even private hospital charges, when left unpaid by a child's family, may ultimately re-

(footnote continued)

related programs bear undue burdens in serving children who are erroneously excluded from SSI and related Medicaid eligibility.

vert to state-subsidized uncompensated care pools. See, e.g., Mass. Gen. Laws ch. 118F, §§ 15, 17 (Supp. 1988). Through such mechanisms, state funds ultimately fill some of the gap that is created when SSA policy causes chronically ill and disabled children to be excluded from the program that Congress intended to fund their care.^{10/}

^{10/} State-subsidized insurance or quasi-insurance programs may also assist in paying the costs of health care for these children. For example, the Massachusetts "CommonHealth" program, Mass. Gen. Laws ch. 118E, § 6B (Supp. 1988), provides health benefits to disabled children who are not eligible for SSI. This program is designed for families who are financially ineligible for SSI; the Massachusetts statute incorporates the SSI disability standards. Disability determinations for the program, however, are made separately from SSI determinations. Thus, it is possible that some disabled children who are improperly rejected from SSI may participate in this state-funded program.

These state-funded programs, numerous and costly as they are, do not ensure a disabled child's access to necessary services. Without SSI benefits and associated Medicaid coverage, some children will not receive preventive and rehabilitative services that would promote their development.^{11/} Ultimately, for some of these children, such deprivation will result in greater life-long dependency on publicly-funded services, including institutional care, than would otherwise have been necessary. For the

^{11/} A New York official has estimated that as many as 25% of the disabled children who may be eligible for SSI in that State are not recipients of any public assistance program at present. These children are unlikely to be receiving timely and adequate medical care and other associated services, which might ameliorate or improve their conditions.

states, that result means vastly increased costs, particularly for mental health and mental retardation services. Similarly, a chronically-ill child's lack of access to preventive health care may lead to increased hospitalization, at least some of the costs of which may fall to a state.

D. Additional Long-Term Costs.

Unduly restrictive SSI policies impose additional, less direct costs on the states. The stress placed on an entire family by a child's chronic illness or disability is obvious and well documented. See generally N. Hobbs, et al., Chronically Ill Children and Their Families, pp. 62-101 (1985). Financial strain due to unreimbursed expenses for medical care or related services adds

substantially to that stress. Id. at 89. The consequences of such stress are high in both human and financial costs. Such consequences include increased family disintegration, mental and physical illness among all family members, homelessness, child abuse, substance abuse, and a variety of other manifestations of family dysfunction. See generally id. Each of these consequences, in turn, may increase demand for various state-funded benefits and services. For an undeterminable number of families, SSI could ease the strain sufficiently to prevent such consequences, and thus to obviate the need for additional state-funded services.

Because Congress intended to place the burden of caring for low-income dis-

abled children on the federal government, the cost of services provided to them and their families through these various types of programs is an unwarranted drain on state budgets. Thus, by adopting an eligibility determination policy that excludes large numbers of severely disabled children, SSA has undermined the legislative purpose and circumvented the will of Congress.

II. THE COURT NEED NOT DEFER TO THE SOCIAL SECURITY ADMINISTRATION'S ERRONEOUS INTERPRETATION OF THE GOVERNING STATUTE.

The Court of Appeals correctly concluded that the regulations at issue are invalid because they are inconsistent with the clear intent of Congress. Zebley v. Bowen, 855 F.2d 67, 73-74, 76

(3d Cir. 1988). Accord Marcus v. Bowen, 696 F. Supp. 364, 382-84 (N.D. Ill. 1988), appeal pending, No. 89-2717 (7th Cir.). Under the circumstances, the Court of Appeals also properly declined to defer to the SSA's contrary interpretation of that statute. 855 F.2d at 72-73. Accord Marcus v. Bowen, 696 F. Supp. at 384.

Whether an agency's regulations exceed statutory authority is a pure question of statutory construction for the court to decide. NLRB v. United Food and Commercial Workers Union, 484 U.S. 112, 105 S. Ct. 413, 421 (1987), relying on INS v. Cardoza-Fonseca, 480 U.S. 421, 446-49 (1987), and Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-43 and n.9

(1984). In answering that question, the court first tries to determine congressional intent using "traditional tools of statutory construction," namely, the plain language, structure, and history of the statute. NLRB, 484 U.S. at ___, 108 S. Ct. at 421 and cases cited; see INS, 480 U.S. at 449. If a clear congressional intent can be discerned in this manner, then the agency's regulations must be "fully consistent" with Congress's intent. NLRB, 484 U.S. at ___, 108 S. Ct. at 421. It is only where these tools fail to reveal Congress's intent that any deference to the agency's interpretation of the governing statute is appropriate. E.g., Regents of University of California v. Public Employment Relations Board, 485 U.S. 589, ___, 108 S. Ct. 1404, 1412 (1988)

("Because we have been able to ascertain Congress's clear intent based on our analysis of the statutes and their legislative history, we need not address the issue of deference to the agency"); Board of Governors, FRS v. Dimension Financial Corp., 474 U.S. 361, 368 (1986), quoting Chevron, 467 U.S. at 842-43 ("If the statute is clear and unambiguous 'that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.'").

The Court of Appeals properly recognized that the starting point for ascertaining Congress's intent is the plain language of the statute itself. 855 F.2d at 73. E.g., American Tobacco Co. v. Patterson, 456 U.S. 63, 68 (1982).

Since courts must assume that the ordinary meaning of the words used by Congress expresses Congress's intent, that plain language is conclusive unless there is a clearly expressed legislative intention to the contrary. Id. at 68, 72 n.6, 75 and cases cited.^{12/} Indeed, this Court often decides cases solely on the basis of the plain language without resort to legislative history. E.g., Bethesda Hosp. Ass'n v. Bowen, 485 U.S. 399, ___, 108 S. Ct. 1255, 1258 (1988); Burlington Northern R. Co. v. Oklahoma Tax Commission, 481

^{12/} See also Rodriguez v. U.S., 480 U.S. 522, 525 (1987); Burlington Northern R. Co. v. Oklahoma Tax Commission, 481 U.S. 454, 461 (1987); Escondido Mut. Water Co. v. LaJolla Band of Mission Indians, 466 U.S. 765, 772 (1984); Dickerson v. New Banner Institute, Inc., 460 U.S. 103, 110, 118 (1983); Griffin v. Oceanic Contractors, Inc., 458 U.S. 564, 570-571 (1982).

U.S. 454, 461 (1987). See also American Tobacco Co., 456 U.S. at 75 ("Going behind the plain language of a statute in search of a possibly contrary congressional intent is a 'step to be taken cautiously,' even under the best of circumstances.").

After comparing the plain language of 42 U.S.C. § 1382c(a)(3)(A) (1982) to the Secretary's regulations, the Court of Appeals properly concluded that,

in the statutory directive that 'any' impairment may be disabling if severe enough, Congress has clearly expressed an intention that children be given the opportunity for individual evaluations comparable to the residual functional capacity assessment for adults. This intent is contrary to that of the agency, which is to restrict children to listed impairments.

855 F.2d at 76.^{13/} There is nothing

^{13/} The Court of Appeals' conclusion is bolstered by the use of the words

(footnote continued)

in the legislative history which clearly expresses a contrary legislative intent. Indeed, as the Court of Appeals discussed, the legislative history supports the plain meaning of the statute. 855 F.2d at 74-75. Accord Marcus v. Bowen, 696 F. Supp. at 370-71. Accordingly, the Court of Appeal's decision that the Secretary's regulations are invalid should be affirmed.

CONCLUSION

For the reasons set forth herein, this Court should affirm the decision of

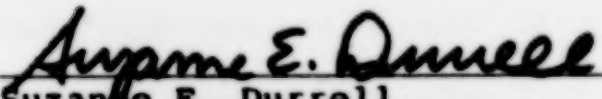
(footnote continued)

"comparable severity" in 42 U.S.C. § 1382c(a)(3)(A) (1982).

the Court of Appeals for the Third
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In The
Supreme Court of the United States
October Term, 1969

**LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES,**

Petitioner,

v.

BREAN SMILEY, et al.,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Third Circuit

**AMERICAN MEDICAL ASSOCIATION,
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QUESTION PRESENTED

Whether the regulatory scheme utilized by the Secretary of Health and Human Services for determining when a child is eligible for disability benefits under 42 U.S.C. § 1382c(a) is consistent with Congress's intent and sound medical practice.

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IN THE
Supreme Court of the United States

OCTOBER TERM, 1989

No. 88-1377

LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES,
v. *Petitioner,*

BRIAN ZEBLEY, *et al.*,
Respondents.

On Writ of Certiorari to the
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for the Third Circuit

AMERICAN MEDICAL ASSOCIATION,
AMERICAN ACADEMY OF PEDIATRICS,
NATIONAL ORGANIZATION FOR
RARE DISORDERS, INC. AND
THE SPINA BIFIDA ASSOCIATION OF AMERICA
AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICI CURIAE*

Amicus American Medical Association ("AMA") is a private, voluntary, non-profit organization of physicians. The AMA was founded in 1846 to promote the science and art of medicine and to improve the public health. Its 280,000 members—over half of all physicians currently licensed to practice medicine—provide care in all fields of medical specialization, including pediatrics.

Amicus American Academy of Pediatrics ("AAP") was founded in 1930 in order to create an independent

forum for the special health and development needs of children. It is a nonprofit association of approximately 38,000 physicians in the United States, Canada and Latin America certified in the specialized care of infants, children and adolescents. The AAP's principal purpose is to ensure the attainment by all children of their full potential for physical, emotional and social health.

Amicus National Organization for Rare Disorders, Inc. ("NORD") is a non-profit voluntary health agency of medical researchers, voluntary agencies and individuals dedicated to the identification, control and improved treatment of rare orphan diseases, those diseases which individually afflict fewer than 200,000 Americans. There are more than 5,000 orphan diseases, which touch the lives of an estimated 20 million people in this country. A disproportionate number of those afflicted by rare diseases are children.

Amicus Spina Bifida Association of America ("SBAA") is a nonprofit charitable membership organization that provides support for children and adults with spina bifida and their families. SBAA has 80 chapters across the country who provide volunteer support and advocacy for families and medical and other professionals who live with and care for people with spina bifida. SBAA supports research efforts into the cause and treatment of spina bifida, public awareness, development of educational materials and advocates improved medical care and social services to those afflicted with this most common disabling birth defect.

Amici's interest in this case derives from a shared concern for the welfare of patients—SBAA and NORD for the particular populations they serve, and AMA and AAP for overall patient care. *Amici's* extensive experience in identifying and treating children who are afflicted by disabling physical and mental impairments permits them to offer the Court unique insights into the assumptions behind and operation of the regulatory system for compen-

sating the disabled implemented by the Secretary of Health and Human Services.

In particular, *amici* are profoundly troubled by the approach followed by the Secretary because it systematically fails to provide assistance to those most disadvantaged of all in our society, viz, poor, disabled children. The Secretary's present interpretation of Title XVI is especially disturbing to *amici* because a child's eligibility for Medicaid assistance, a crucial source of funds for essential medical care for low income individuals, is often tied directly to a Title XVI disability determination. See generally, Fox & Greaney, *A Preliminary Assessment of Disabled Children's Access to Supplemental Security Income and Medicaid Benefits* 4-5, 42 (Washington, D.C. Dec. 1988). Thus, when a child is denied benefits under Title XVI, funds for vital medical care are significantly delayed and may be completely denied, which can only exacerbate the developmental problems these children will experience. Accordingly, *amici* wish to present their views concerning why the Secretary's approach is not only inconsistent with good medical practice but also manifestly inconsistent with Congress's intent when it included children within the coverage of Title XVI.¹

MEDICAL BACKGROUND

A. The Importance Of Development And Functional Capacity In Pediatric Medicine.

Children's health needs differ from those of adults in part because of the different ways children think, experience emotion or pain, respond to stress, metabolize drugs and manifest disease. A primary concern of pediatric medicine is to prevent potentially debilitating illness or injury from arresting a child's development of the characteristics and skills essential to adulthood. Thus, while

¹ Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. Their letters of consent have been filed with the Clerk of Court.

all physicians are concerned with the health of their patients, pediatricians and other physicians who treat children share a special, additional obligation: to help their patients *develop* so that they may attain "their full potential for physical, mental, emotional and social health."²

The developmental component of the practice of pediatrics has implications that are very important to respondents in this case. Good pediatric medical practice requires a physician to pay close attention to the effects of illness or injury on developing functional skills—cognitive, emotional and social, as well as physical—which are essential to the child's successful growth into self-sufficient adulthood. The physician's task includes not only treating the child's immediate illness or injury, but also identifying the steps that are essential to permit the child's overall development to proceed as normally as possible. See generally Guralnick & Bennett, A Framework for Early Intervention, in *The Effectiveness of Early Intervention for At-Risk and Handicapped Children* 14, 24 (Guralnick & Bennett eds. 1987) ("Effectiveness of Early Intervention").

The pediatric literature is replete with examples of the importance to pediatric medicine of functional assessments. In the area of pediatric research, assessments of children's cognitive, emotional, social and physical condition are routinely analyzed through research into children's play. *E.g.*, Fein, *Pretend Play In Children: An Integrative Review*, 52 *Child Development* 1095,

² The adult's internist "specializes in the diagnosis and medical, as opposed to surgical and obstetrical, treatment of diseases of adults." *Dorland's Illustrated Medical Dictionary* 673 (26th ed. 1985). The child's pediatrician practices "that branch of medicine which treats diseases of the child and [the child's] *development* and care of the diseases of children and their treatment." *Id.* at 979 (emphasis supplied). As stated in the Preamble to the Constitution of *Amicus American Academy of Pediatrics*, the Academy's "fundamental goal" is to assure "that all children and youth have the opportunity to grow up safe and strong, with faith in the future and in themselves."

1109 (1981); Ghiaci & Richardson, *The Effects of Dramatic Play Upon Cognitive Structure and Development*, 136 *J. Genetic Psychology* 77 (1980). In addition, pediatricians routinely include among the goals of treatment of any childhood disease, as well as management of its symptoms, "help[ing] the child perform ordinary daily age-appropriate activities." Schwartz, *Children with Chronic Asthma: Care by the Generalist and the Specialist*, 31 *Pediatric Clinics of North America* 87, 89 (1984).

The view that proper study or treatment of pediatric illness and injury must include an assessment of the child's functional capacity to perform age-appropriate activities is well accepted in the medical community.³ This view takes on special importance when the physician is called upon to assess a child's condition according to the severity of his or her medical condition. The biological severity of an illness is an abstraction, measured only by proxies, the most familiar of which are physiological severity, functional severity and burden of illness. Stein, *et al.*, *Severity of Illness: Concepts and Measurements*, II *The Lancet* 1506, 1507 (December 26, 1987). Physiological severity may be greatly altered by therapy and social circumstances. For instance, emotional stress can exacerbate the physiological severity of several fairly common childhood diseases, including asthma, inflammatory bowel disease, juvenile rheumatoid arthritis and diabetes. *Id.* Partly for this reason, disease-specific measures of physiological severity are often questionable, and

³ Many pediatric commentators have pointed out the inadequacy of any medical diagnosis that does not include an assessment of the child's functional ability to perform age-appropriate tasks. For example, a major pediatric text concludes a chapter on diagnosis with the observation that where information is missing about the child's performance in one developmental area, such as cognitive skill, the pediatrician simply must refrain from making a final diagnosis in another area, such as the origins of a behavioral problem with school adjustment. See Levine, *et al.*, *Developmental-Behavioral Pediatrics* 1039 (1983).

there is general agreement that such measures are of little use in children with, *inter alia*, rare conditions or multiple disorders. *Id.* Consequently, there is no way meaningfully to separate a clinician's functional assessment from medical diagnosis and treatment of many childhood disabilities and any attempt to do so distorts proper medical practice.

B. Good Pediatric Practice Requires Individualized Medical Assessments.

Pediatricians widely agree, for several reasons, that effective diagnosis and treatment of childhood disability, or of potential disability in the case of the child "at risk," requires the exercise of individualized medical judgment. *E.g.*, Healy, *et al.*, *Early Services for Children With Special Needs: Transactions for Family Support* (2d ed. 1989). First, where chronic illness in adults "consists mainly of a relatively large number of fairly common illnesses (such as hypertension, diabetes and osteoarthritis) and a few rare diseases, chronic illness in childhood is characterized by very few disorders that are common and by many that are quite rare." Pless & Perrin, *Issues Common to a Variety of Illnesses*, in *Issues in the Care of Children with Chronic Illness* 41, 43 (Hobbs & Perrin eds. 1985). Because there are so many rare diseases of childhood, it is unlikely that any individual physician, who will see only a few, if any, such cases in a lifetime of practice, will become expert in the diagnosis or treatment of many rare childhood diseases. The nature of childhood disease thus emphasizes the need for a careful and comprehensive assessment of each individual child. See, *e.g.*, Schwartz, *Children with Chronic Asthma: Care by the Generalist and the Specialist*, 31 *Pediatric Clinics of North America* 87 (1984).

Second, an individualized assessment of disability is important because individual variables have a significant

impact on the child's overall condition and development.⁴ An individualized assessment is essential in order to make adequate diagnoses and treatment plans. Finally, as discussed above, pediatric medicine serves a developmental as well as a treatment-of-illness purpose. Adequate assessment of a child's condition at any given time necessarily includes a broad view of his or her functional abilities across a range of developmental dimensions. To draw together the disparate evidence needed to make a competent and comprehensive diagnosis and treatment plan, the physician must give careful attention to each child's individual circumstances and functional abilities.

C. The Importance Of Early Intervention In Treating Disabling Impairments Among Children.

The developmental goal of pediatric medicine has another implication for good medical practice: medical intervention should occur before illness or injury becomes sufficiently severe to affect the child's functioning in other developmental dimensions. It is well-established, for example, that children with documented handicaps have more difficulty establishing secure attachments with their parents during infancy,⁵ and developing peer rela-

⁴ For example, in the area of memory, research has shown that it is the child's individual cognitive development, not his or her chronological age, that determines ability. Walker *et al.*, *Cross-Cultural Research with Children and Families*, in *Handbook of Clinical Child Psychology* 74 (Walker & Roberts eds. 1983). Similarly, research has shown that individual differences in temperament can affect a child's development. *Id.* at 75.

⁵ Guralnick & Bennett, *A Framework for Early Intervention, in Effectiveness of Early Intervention* at 14. See also Healy, *et al.*, *Early Services for Children with Special Needs* 21-25 (2d ed. 1989). This difficulty is thought to be caused by the handicapped child's inability to signal and display affective responses that engage the parent. Guralnick & Bennett, *A Framework for Early Intervention, in Effectiveness of Early Intervention* at 15. This pattern has been documented in children with several different kinds of disabilities: hearing impairments, Down syndrome, other developmental delays and cerebral palsy. *Id.* See also Perrin, *et al.*,

tionships and general communicative skills. Guralnick & Bennett, *A Framework for Early Intervention*, in *Effectiveness of Early Intervention* at 16-17. These deficiencies can have far-reaching effects. For example, without early intervention to prevent or minimize these secondary deficits that result from the child's primary handicap, the child may be tracked into an educational program more restrictive than his or her abilities would allow if properly treated early. As a result, the child may never reach full adult potential, and some children who could have become self-sufficient adults will not develop that capacity.⁶ It is therefore vital that children with significant medical impairments receive early professional care and any regulatory approach that decreases the likelihood that younger children will receive medical attention will have potentially devastating and long-term consequences for those children.

In sum, the developmental goal of pediatric medicine has important implications for the issues presented in this litigation. Good medical practice calls for treatment to be preceded by comprehensive, individualized assessments of the child's medical condition, including his or her ability to perform age-appropriate functions.

SUMMARY OF ARGUMENT

I.

Nearly 20 years ago, Congress established the Supplemental Security Income program to provide benefits to financially needy individuals who are aged, blind, or disabled. This Court has previously recognized that Congress

Parental Perceptions of Health Status and Psychologic Adjustment of Children with Asthma, 83 *Pediatrics* 26 (1989).

⁶ The available evidence is that early intervention works. For example, the measured decline in Down syndrome children's intelligence as they grow older can be prevented and to some extent reversed with the adoption of appropriate early intervention strategies. Guralnick & Bricker, *Cognitive and General Developmental Delays*, in *Effectiveness of Early Intervention* at 135-67.

intended that all disability determinations under the SSI program would be based on an individualized assessment. *Heckler v. Campbell*, 461 U.S. 458, 467 (1983). And, in fact, the Secretary has established a regulatory scheme for *adults* that provides for individualized disability determinations based on the functional impact of physical and mental impairments.

From the inception of this program, Congress explicitly sought to extend the program's benefits to disabled children, because, in Congress's words, they are "among the most disadvantaged of all Americans and . . . are deserving of special assistance." S. Rep. No. 1230, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Admin. News 5132, 5133. Congress further intended that children, like adults, would be considered for benefits based on an individualized consideration of the functional impact of their physical and mental impairments. Nevertheless, the Secretary has in recent years adopted restrictive regulations that prevent such individualized determinations for children and thus deny significant numbers of disabled children from low income households the benefits that Congress intended them to receive.

The Secretary's present interpretation of the statute as it applies to children is plainly at odds with the language of the statute as well as with the contemporaneous and subsequent legislative history. Moreover, the Secretary's present restrictive interpretation is contrary to his own interpretation as disseminated within the agency, and communicated to Congress, in the program's early years. At that time, the Secretary fully and correctly acknowledged the importance of considering the impact of a medically determinable impairment on the individual child's growth, development and maturation. See Social Security Administration Disability Insurance Letter No. III-11 (Sept. 7, 1973) (J.A. 90). It was *this* interpretation of the statute that Congress was aware of in 1976, *not* the Secretary's more recent listings-only ap-

proach, reflected most clearly in a policy statement some seven years later. Social Security Ruling 83-19 (1983) (J.A. 236). Thus, any acquiescence by Congress in 1976 reflected continued support for individualized disability determinations, including an individualized assessment of the functional impact of each child's physical or mental impairment.

II.

The deference in interpreting the statutes he administers that the Secretary is customarily accorded by this Court is not sufficient to justify his present regulatory scheme. The regulatory history of the program contradicts the Secretary's suggestion that his interpretation of the statute should be respected here because it is longstanding. Moreover, the individualized consideration of functional factors is quite feasible and, in fact, required under sound medical practice. As the Secretary himself has recognized, the listings necessarily exclude many disabling conditions. Because of the particular manifestation of disability in children, this inherent limitation has particularly damaging consequences that are not ameliorated by the Secretary's medical equivalence regulations. By prohibiting an individualized assessment of each child's medically determinable impairment and resulting functional limitations, the Secretary has established a regulatory system that is arbitrary and capricious.

ARGUMENT

I. THE SECRETARY'S REGULATORY SCHEME FOR DETERMINING WHEN CHILDREN ARE ELIGIBLE FOR DISABILITY BENEFITS UNDER THE SUPPLEMENTAL SECURITY INCOME PROGRAM IS INCONSISTENT WITH THE STATUTORY LANGUAGE AND WITH CONGRESS'S INTENT.

It is well established that agencies are accorded considerable latitude in construing the statutes that they administer. *Chevron, U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837 (1984). Moreover, the Sec-

retary has been given reasonably broad authority to establish standards for applying certain sections of the Social Security Act, *Bowen v. Yuckert*, 482 U.S. 137, 145 (1987). However, the deference accorded to an agency's interpretation is not absolute: if the intent of Congress is clear, the agency and the courts must give effect to that congressional intent. *Chevron*, 467 U.S. at 842-43. And, even where Congress has not directly addressed the precise question, the agency's interpretation may be rejected where the court determines that the agency's interpretation is not reasonable. *Id.* at 843-44. In the present case, it is clear that the congressional scheme contemplates that the Secretary will conduct "individualized [disability] determinations . . . of each individual's condition." *Heckler v. Campbell*, 461 U.S. 458, 467 (1983).⁷ As we show below, the Secretary has implemented that approach for adults but not children.

A. The Statutory Language Requires The Secretary To Consider Individual Functional Impairment In Making Assessments Of Childhood Disability.

The Supplemental Security Income (SSI) program, enacted in 1972 as Title XVI of the Social Security Act, 42 U.S.C. § 1381 *et seq.* (1981 & Supp. IV 1986), generally provides benefits to financially needy individuals who are aged, blind or disabled. See *Schweiker v. Wilson* 450 U.S. 221, 223 (1981), quoting S. Rep. No. 1230, 92d Cong., 2d Sess. 4, 12 (1972).

The Social Security Act provides that an individual is eligible for disability benefits when:

he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected

⁷ Because the Title XVI provisions that are at issue in this case were patterned on the previously enacted Title II language found at 42 U.S.C. § 423, it is customary to refer to the cases that have interpreted Title II when construing the meaning of the identical Title XVI language. *Bowen v. City of New York*, 476 U.S. 467, 470 (1986).

to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

42 U.S.C. § 1382c(a)(3)(A). For a wage earner, the statute requires that the Secretary determine if the claimant is unable to "engage in any other kind of substantial gainful work which exists in the national economy . . ."

42 U.S.C. § 1382c(a)(3)(B). For a child, however, the statute does not specify the level of impairment, other than to say that it must be of "comparable severity."

42 U.S.C. § 1382c(a)(3)(A). For both adults and children, the statute provides that a physical or mental impairment is one which "results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." 42 U.S.C. § 1382c(a)(3)(C). At issue in this case is the appropriate meaning of the phrase "any medically determinable physical or mental impairment of comparable severity."

In interpreting the phrase "comparable severity," it is helpful initially to review the regulations enacted by the Secretary for adults. These regulations establish a five-step process designed to ensure each adult an individualized determination of disability. 20 C.F.R. § 416.920 (1986). In the first three steps, the Secretary evaluates whether the individual is engaging in any substantial gainful activity; if not, then the Secretary looks for the existence of a medically severe impairment; and if such an impairment is found to exist, whether that impairment is equivalent to one of a number of listed impairments that are extremely severe. 20 C.F.R. § 416.920(d); 20 C.F.R. pt. 404, subpt. P, App. 1 (1986) (commonly referred to as the Part A listings). If the impairment meets or equals a listed severe impairment, the claimant is "conclusively presumed to be disabled." *Bowen v. Yuckert*, 482 U.S. at 141. The listings thereby serve to

identify quickly and uniformly claimants whose impairments are so severe that an individualized assessment of the functional impact of the impairment is unnecessary because benefits clearly should be paid.

If an adult fails to establish that his impairment is medically equivalent to one of the Part A listed (conclusively disabling) impairments, the adult is allowed to proceed to a fourth step where the Secretary evaluates the claimant's residual functional capacity to determine whether the impairment prevents the claimant from doing work he has performed in the past. 20 C.F.R. § 416.920(e). If the claimant cannot perform his past relevant work, he proceeds to the fifth and final step where the Secretary evaluates whether, considering the claimant's residual functional capacity, age, education and past work experience, he can perform other work in the national economy. 20 C.F.R. § 416.920(f). See generally *Bowen v. Yuckert*, 482 U.S. at 141.

In contrast, the Secretary restricts a child to showing that his impairment strictly meets or equals the exact medical criteria in a listed impairment. Like the Part A listings for adults, the Part B listings reflect commonly occurring impairments in children that are of such severity that the Secretary has determined that *no* individual evaluation of the impairment's impact on the child is necessary (other than to the limited extent that some of the listings refer to functional impact) in order to presume conclusively that the child is disabled. 20 C.F.R. pt. 404, subpt. P, App. 1 (1986) (both Part A and Part B listings are contained in the same appendix). Thus, a child can be found to be disabled only if he meets or equals the strict medical factors of a *conclusively disabling* impairment. Under the Secretary's present policy for children, no amount of actual functional restriction, however severe, can be considered outside of the exact medical criteria in a listed impairment. See Social Security Ruling 83-19 (J.A. 243) and *infra*, 25-26.

The result of these different regulatory schemes is that a child will be conclusively denied benefits with-

out any recourse to an individualized showing when an adult with an *identical* impairment of *identical* severity with *identical* effects on function in a relevant sphere is entitled to make a showing that could permit him to receive benefits. See, *e.g.*, depositions of Dr. Bertram Kushner, a disability reviewing physician (J.A. 74-75) and Dr. Jerome Shapiro, SSA medical consultant (J.A. 85-87).

Congress did not set out specific functions that children perform that could be compared directly to the ability to work for adults. Nevertheless, it is reasonable to infer from the congressional emphasis on the functional impact of physical or mental impairments on adults that Congress intended disabling determinations concerning children to be similarly concerned with the impact of the impairment on the individual child's ability to function in a relevant sphere. Such an interpretation also gives the most natural reading to the phrase "comparable severity."

By using the phrase "comparable severity" it is reasonable to infer that Congress was not insisting that the Secretary utilize absolutely identical procedures or criteria for children as for adults. However, the use of this phrase in conjunction with a functionally focused statutory definition of disability for adults in fact underscores Congress's concern that disability determinations for *both* children and adults reflect the functional impact of impairments. Any impairment that is "medically determinable" as further specified in 42 U.S.C. § 1382c(a)(3)(C) and that results in the requisite limitation on the individual's ability to function within age-appropriate expectations should render the individual eligible for benefits.

The Secretary's interpretation of the phrase "medically determinable" is not persuasive. The Secretary draws a distinction between permissible "medical factors," which he appears to believe are embodied solely in the present listings, and all other evidence, referred to as "amorphous . . . unspecified non-medical factors," which he argues are

wholly outside of the intended statutory scheme. Pet. Br. 15. However, the statute requires only that an *impairment* be "demonstrable by medically acceptable clinical and laboratory diagnostic techniques." 42 U.S.C. § 1382c(a)(3)(C). As discussed above, medically acceptable clinical findings, especially in the area of pediatric disability, must be interpreted in light of the functional impact of a physical or mental impairment and are of sufficient variety to defy complete description in any listing. See *supra*, 3-6. Thus the statute's reference to "medically acceptable" techniques for determining impairments cannot fairly be read to exclude consideration of functional elements.*

B. The Legislative History Supports The Statute's Plain Language.

The legislative history accompanying Title XVI supports the view that Congress was concerned with the functional impact of physical and mental impairments on children. The House report accompanying the newly created Title XVI expressed Congress's concern that "disabled children who live in low-income households are certainly among the most disadvantaged of all Americans and . . . are deserving of special assistance in order to help them become self-supporting members of our society." S. Rep. No. 1230, 92d Cong., 2d Sess., *reprinted* in 1972 U.S. Code Cong. & Admin. News 5132-5133. Congress recognized explicitly that without financial assistance, such disabled children might never acquire the schooling and other skills necessary to function in the workforce as adults. *Id.* at 5138.

Congress again indicated expressly its understanding that Title XVI was intended to consider the functional impact of physical and mental impairments afflicting

* The Secretary's argument is further undermined by his own present regulations which, in the case of adults, note that residual functional capacity is a "medical assessment," that necessarily is concerned with the functional impact of physical and mental impairments. 20 C.F.R. § 416.945(a).

children when, in 1976, Congress specifically directed SSA to promulgate long-promised additional criteria and definitions for disability determinations of children under the age of 18. Furthermore, sponsors of the 1976 SSI disability amendments underscored Congress's primary concern with helping those low-income children with disabilities that threaten to render them disabled as adults. Senator Hathaway, a co-sponsor of the 1976 legislation, stated:

This test of comparable severity for a child's disability is required in current law. Like the test for determining the disability of an adult, a disability is not determined solely on medical grounds but also includes an evaluation of the impact of the disability on the person's abilities. In the case of an adult, that impact is looked at in light of his ability to engage in substantial gainful activity; the child's disability is to be looked at in terms of the comparable severity of its impact. Vocational ability, however, is clearly not a relevant test for determining the impact of a disability on a child. The assessment, rather, should refer to the impact of the child's handicap on his ability to function successfully within age-appropriate expectations. The child's functional capacity within the area of learning, language, self-help skills, mobility and social skills are decidedly more meaningful in determining both the severity of the impairment and the development potential of the child.

122 Cong. Rec. S. 34,026 (1976). In addition, Senator Hathaway recognized that the Secretary should consider broadly all relevant information concerning the individual child's condition. Thus, the Senator explained:

Medical criteria used in the broad sense of the total health development of the child could indeed provide the basis for determining the comparable severity of a child's disability. Medical criteria which are restrictively drawn . . . are not going to provide a definition of disability relevant to the person under the age of 18. A test of comparable severity is needed and is required in the present definition of disability

for such persons; but it should be based on tests relevant to a child, to his social and educational development

Id. See also 122 Cong. Rec. H. 27,855 (1976) (remarks of Rep. Mikva) and 122 Cong. Rec. S. 33,301-02 (1976) (remarks of Sen. Bentsen). Although such subsequent legislative history may be considered less dispositive of congressional intent than contemporaneous legislative history, see, e.g., *CPSC v. GTE Sylvania, Inc.*, 447 U.S. 102, 118 n.13 (1980), the later legislative history's declaration of an earlier statute's intent is entitled to "great weight" when that later declaration is based on an administrative construction that is consistent with it. *Red Lion Broadcasting Co. v. FCC.* 395 U.S. 367, 380-81 (1969). The Secretary had established a construction of the statute prior to 1976 that did require individualized assessments of each child's functional limitations. See *infra*, 19-20. Thus, the legislative history in 1976 is probative of Congress's intent to require individualized consideration of functional elements.

C. Congress Never Acquiesced In The Secretary's Current Interpretation.

The Secretary argues that his present interpretation of "comparable severity" is entitled to substantial deference because Congress was aware of and supported that interpretation at the time it enacted amendments to Title XVI in 1976 as part of the Unemployment Compensation Amendments of 1976, Pub. L. No. 94-566, § 501, 90 Stat. 2667. Pet. Br. 30-35. However, Congress has not ratified the Secretary's current interpretation because it was not aware of, could not have been aware of and would not have agreed to that interpretation when it acted in 1976. Indeed, the Secretary's present interpretation was not even formulated until significantly *after* the 1976 amendments.

As of 1976 the Secretary had maintained a consistent interpretation of the statute which *did* permit individualized determinations based on medical assessments of the functional impact of physical and mental impairments.

See *infra*, 19-20. Not only was that interpretation presented to the Congress, but the statements of the members most actively involved in the legislation indicate support for that interpretation. See *supra*, 16-17. Senator Hathaway, who served on the Conference Committee and whose amendment calling for the development of more explicit criteria for pediatric disability determinations was ultimately adopted, noted that the statutory test of comparable severity requires consideration of "the impact of the child's handicap on his ability to function successfully within age appropriate expectations. . . ." 122 Cong. Rec. S. 34,026 (1976). Similarly, there is nothing in the legislative history accompanying the 1976 amendments indicating any awareness of or support for a strictly limited "meets or equals a listed impairment" interpretation of comparable severity. The Senate report accompanying the amendments focuses solely on Congress's dissatisfaction with the lack of specific guidance from SSA and the resulting disparities in how similarly afflicted children in different states were being treated under the statute. There is simply no support for the Secretary's contention that Congress was aware of, much less acquiesced in, the Secretary's current restrictive policy.

In sum, the Secretary's belated (and inconsistent) attempt to cabin the meaning of "any medically determinable physical or mental impairment of comparable severity" in a way that excludes the impact of impairments on a child's functioning is contrary to the statutory language, Congress's intent in 1972 and Congress's assumptions in 1976 about the agency's own prior interpretation of that language.

II. THE SECRETARY'S PRESENT INTERPRETATION IS NOT ENTITLED TO DEFERENCE.

This Court has looked to a number of specific factors when determining whether a particular regulation properly carries out Congress's intent, including whether the regulation was a contemporaneous construction of the

statute; if the regulation was promulgated at a later date, how it evolved; the length of time the regulations have been in effect; the reliance placed on the regulations; the consistency of the agency's interpretation and the extent of Congressional scrutiny during any subsequent reenactments of the statute. *National Muffler Dealers Ass'n v. United States*, 440 U.S. 472, 477 (1979). An evaluation of these factors as they apply to the regulations implemented by the Secretary governing disability determinations for children under 42 U.S.C. § 1382c, even according the agency the most deferential standard of review, compels the conclusion that the regulations violate Congressional intent and are arbitrary and capricious.

A. The Secretary's Interpretation Is Not Longstanding.

In the years immediately following the passage of Title XVI, the Secretary, contrary to the position now stated in his brief, Pet. Br. 38-41, consistently interpreted "comparable severity" to encompass individualized determinations of the functional impact of impairments on children. In both 1973 and 1974, the Secretary issued Disability Insurance Letters to guide agency employees in the evaluation of childhood disability under the newly enacted SSI program.⁹ These earliest interpretations reflect a clear understanding by the Secretary of Congress's concern with the functional impact of impairments. Writing in 1973, the Secretary declared that "disability in children must be defined in terms of the primary activity in which they engage, namely growth and development, the process of maturation." J.A. 90. Therefore, the Secretary concluded that "comparable severity" should be applied to mean that "the severity of the impact of the child's impairment(s) must be 'comparable'

⁹ The Disability Insurance Letters ("DILs"), circulated by the SSA for internal use, represented the SSA's primary directives to state agencies on standard policies and operating procedures for making child disability determinations. Pet. Br. 36. Moreover, the DILs relevant to this case contain the Secretary's earliest statements interpreting the meaning of the statutory language relating to disability determinations for children. *Id.* at 36, 38.

to the severity of the impact of an impairment(s) which would prevent an adult from engaging in any substantial gainful activity." *Id.* at 91. (emphasis in the original).

The next year, in a supplement to the 1973 Disability Insurance Letter No. III-11, the Secretary referred to an impairment which interferes with a child's maturation as the equivalent of an impairment which prevents an adult from engaging in substantial gainful activity. *Id.* at 96. The Secretary specifically noted that the process of maturation involves:

(1) growth—increase in size and maturation of physical and functional characteristics, (2) learning, (3) mastering basic skills, and (4) emotional and social development . . . [t]he factors to be compared are the impact of the child's impairment on the child's life . . .

Id. (emphasis in the original). Moreover, the Secretary alerted those evaluating claims of childhood disability to consider learning and behavioral problems that lead to developmental delay. *Id.* at 96-97. In sum, the Secretary's present interpretation of the statute to preclude individualized consideration of the functional impact of impairments cannot be considered longstanding because it is at odds with the Secretary's contemporaneous interpretation of Title XVI.

B. Consideration Of Functional Impact Is Feasible.

The Secretary's present contention (Pet. Br. 44) that a functional benchmark is not feasible is belied by two facts. First, well-established medical practice *does* use functional benchmarks in evaluating disability in children. See *supra*, 3-6. Second, at the outset of the program the Secretary's policy directives articulated an understanding that Congress intended the statute to require pediatric disability determinations to reflect the functional impact on the individual child of his physical or mental impairment. This seriously undermines the Secretary's present contention that consideration of the functional impact of disability on children is somehow

infeasible or inappropriate.¹⁰ It is true that for children there is no single benchmark for conducting a functional analysis like employment for adults, but there are a number of readily identifiable criteria for evaluating functional performance in children of different ages. Certainly for most children age six to seventeen, school related functions would be a relatively simple standard to apply in an individualized determination. Moreover, the Secretary's artificial process of deciding whether to cubby-hole one medical impairment into a listed category is not inherently simpler or more efficient for the Secretary than making an individualized functional assessment, which physicians and other health professionals must do for each child anyway.

C. Exclusion Of Individualized Functional Assessment Is Contrary To Sound Medical Practice.

There is no basis in sound medical practice for the Secretary's suggestion that childhood disability can properly be determined based solely on "medical" factors that do not include functional considerations beyond those the Secretary has chosen to incorporate in a given Part B listing. Pet. Br. 38, paraphrasing DIL No. III-11 (J.A. 91). Because of the central role that development plays in the medical evaluation and treatment of children, comprehensive functional assessments are an integral part of a physician's evaluation of every child. In fact, it is not only feasible to include functional considerations in making a medical

¹⁰ The Secretary's recently released Notice of Proposed Rulemaking ("NPRM") establishing new listings for pediatric mental impairments underscores the feasibility, importance and propriety of functional factors in making a "medical" assessment of disability under Title XVI. See generally 54 Fed. Reg. 33,238 (Aug. 14, 1989). For example, the Secretary states that "[i]n childhood cases, as with adults, severity is measured according to the functional limitations imposed by the medically determinable mental impairment." 54 Fed. Reg. 33,238, 33,241 (1989) (to be codified at 20 C.F.R. pt. 404, subpt. P, App. 1, pt. B, 112.00C) (proposed Aug. 14, 1989).

assessment of a child's disability; it is absolutely essential. See *infra* 3-6.

1. *The Secretary's listings are inherently incomplete and often outdated.* The Secretary argues that any obligation to incorporate a functional analysis of a child's impairment into the standard used for determining childhood disabilities under § 1382c is met by the Part B listings that apply specifically to children. Pet. Br. 38-42. However, as even the Secretary has admitted, the listings (whether for children or adults) are not comprehensive, but include only those impairments that are more "commonly occurring" (44 Fed. Reg. 18,170, 18,175 (Mar 27, 1979) or "frequently diagnosed" 50 Fed. Reg. 50,068, 50,069 (Dec. 6, 1985). See also 43 Fed. Reg. 14,705, 14,706 (Mar. 14, 1977) (Secretary acknowledges that the children's listings "evaluate the more common impairments" and that children can "have an impairment that is not included in the Appendix.")

What makes the Secretary's slavish reliance upon the listing especially arbitrary is the fact that children manifest a significantly broader range of disabling diseases and conditions than do adults and yet adults are permitted to prove disability beyond the bounds of the listings. It is plainly unreasonable to restrict the universe of disabling conditions to a set of only 57 disorders, especially when those listings are extremely dated. Thus, the current listings exclude such well-known disorders as AIDS, Down syndrome, muscular dystrophy, infant drug dependency and fetal alcohol syndrome. For example, *amicus* National Organization for Rare Disorders has documented over 5,000 diseases and conditions, many of which can be severely disabling, but very few of which are listed in either Part A or Part B of the Appendix.

Even listings of relatively common impairments are totally out of step with current treatment practices. For example, the listing of bronchial asthma still contains a reference to parenteral (injected) medication as a measure of disability. Listing No. 103.03 (J.A. 213). In

fact, this therapy has long been supplanted by oral and inhaled medications for control of pediatric asthma of comparable severity. See generally Schwartz, *Children with Chronic Asthma: Care by the Generalist and Specialist*, 31 *Pediatric Clinics of North America* 87, 99-103 (1984). Similar deficiencies exist in the listings for hearing and vision impairments, where the Secretary's listings specify medical criteria that are inapplicable to infants and very small children. See Listings Nos. 102.02 and 102.08.¹¹

However, physicians long ago developed measures of hearing and vision disability that are widely used with very young children.¹² Despite their accuracy and widespread acceptance in the field, these up-to-date measures and diagnostic modalities will not result in findings of disability under the Secretary's archaic system. Because, unlike adults, children do not have recourse to any evalua-

¹¹ The listing for visual impairment calls for a finding of disability in children under three in only three circumstances: absence of accommodative reflex (which the listing specifically states will not be applied to children under six months), retrolental fibroplasia with macular scarring or neovascularizations (a fibrous growth behind the lens of the eye with a dense, visible scar or with development of new blood vessels), or bilateral cataracts with certain complications. Listing 102.02. The listing for hearing impairment for children under five calls for a finding of disability only for inability to hear air conduction thresholds at an average of 40 decibels or greater in the better ear. Listing 102.08.

¹² Vision can be estimated by observing the response to familiar objects (such as balls) of various sizes, and recording the distance at which the response is elicited. *Nelson's Textbook on Pediatrics* 1447 (Nelson, Behrman & Vaughan eds., 13th ed. 1987). Other widely used measures include optokinetic nystagmus (response to a series of moving targets) and visual evoked response (VER) testing (an electrophysiologic method of evaluating the response to light and special visual stimuli). *Id.* at 1448. Hearing loss in young children can now be measured through observation of behavioral response to noisemakers, auditory brain stem evoked responses (ABER) (computer-generated average of the brain's electrical response latency to auditory stimuli), or automatized infant hearing screening devices. *Id.* at 96-97.

tion outside of the listings (or strict comparisons to the listings), the inherent limitations of the Secretary's approach are more likely to result in inappropriate denials of benefits for children than for adults.

2. *The medical equivalence regulation is overly restrictive.* The Secretary relies heavily on the existence of his "medical equivalence" regulation to salvage the regulatory scheme for children. Pet. Br. 40, 42. However, the regulation, adopted in 1980 (45 Fed. Reg. 55,566, 55,570-71 (Aug. 20, 1980)) fails to provide sufficient latitude to permit individual children to show that their impairments are of "comparable severity" to an impairment which an adult could demonstrate entitled him to a determination of disability.

According to the regulation, a child whose medical findings (symptoms, signs and laboratory findings) do not meet the medical findings of one of the impairments listed in Part B or, if there is no separate listing under Part B, in Part A, can only be found to be disabled if he shows that his impairment is "medically equivalent" to a listed impairment. 20 C.F.R. § 416.926(a). The regulation also states that an impairment is disabling if the Secretary's physician (who need not be a specialist in pediatrics or in the specific impairment) determines that the medical findings of impairment are equal to the medical criteria of an impairment that the Secretary determines most closely matches that manifested by the child. *Id.*

The difficulty with this rather tautological definition is that by insisting on equality of severity with necessarily limited listings, the Secretary prevents a significant number of children from receiving an individualized determination that their impairment is of "comparable severity" to an adult impairment that would be found to be disabling. It is wholly arbitrary to require, for example, that a child with dystrophic epidermolysis bullosa (a rare, life-threatening, blistering disease that affects the skin and internal organs, and that usually leads to death

before the age of 30) demonstrate that his medical findings are "equal in severity" to a listing, such as Catastrophic Congenital Abnormalities or Diseases which applies only if the impairment is either incompatible with extrauterine life or expected to prevent a child from surviving and developing to the level of a two year old. Listing 110.08.¹³ The likelihood that any physician could make meaningful comparisons between extremely rare diseases and the set medical criteria listed by the Secretary means that children will be denied benefits for reasons wholly unrelated to the extent of their disability. This is neither administratively convenient nor rational.

This unrealistically restrictive definition of equivalence has been further limited by a subsequent HHS directive that explicitly *prohibits* a determination that an impairment is "equal" to a listed impairment based on an assessment of equivalent "overall functional impairment." Social Security Ruling ("SSR") 83-19 (J.A. 236).¹⁴ The Ruling further instructs SSA personnel that

[t]he level of severity in any particular listing section is depicted by the *given set* of findings and not by the degree of severity of any single medical finding—no matter to what extent that finding may exceed the listed value The functional consequences of the impairments (i.e. RFC) [Residual Functional Capacity], irrespective of their nature or extent, *cannot* justify a determination of equivalence.

Id. (emphasis in original). Thus, the regulations prohibit a determination of disability in cases where a medical assessment of equivalence is based in part on a de-

¹³ The Secretary has determined that this is the closest listing to epidermolysis bullosa. However, a child with E.B. will not "equal" the specific medical criteria in listing 110.08, despite the fact that the disease is significantly more disabling than many other listed impairments.

¹⁴ Social Security Rulings are statements of policy or interpretive rulings issued by the Secretary that are binding on all SSA adjudicative personnel. *Marcus v. Bowen*, 696 F. Supp. 364, 371 (N.D. Ill. 1988).

termination that *functionally* a child suffers from an impairment of equal severity to a listed impairment. Given the manifold variety of disabling conditions among children, such a strict interpretation of comparable severity ensures that many children who suffer from disabling impairments are unable to receive benefits, even though in any true medical sense their condition is equally disabling.

One compelling example shows why the Secretary's approach should be rejected. Monisha Smith is a ten-month-old infant with spina bifida myelomeningocele. Monisha's disease has resulted in substantial developmental delays, although currently she does not meet the 50% developmental delay criterion as set forth in the Secretary's regulations. Listing 112.05A. Her legs have been affected by some paralysis, so she is unable to crawl. Although all infants are incontinent, Monisha's disease requires that she be catheterized every two hours, and that her bowel be manually vacuated.¹⁵ Unlike other children, who by age two or three gain voluntary bowel and bladder control, Monisha will never gain such voluntary control. Her impairments, although severe and ongoing, do not satisfy the Secretary's current listed standards.¹⁶ Eventually, Monisha's impairments will result in her qualifying for disability benefits, not necessarily because her condition

¹⁵ See Sugar, *The Neurogenic Bladder in the Child with Myelomeningocele: Neurophysiology and Treatment Using Intermittent Catheterization*, in *Spina Bifida: A Multidisciplinary Approach* 70, 72-73 (R. McLaurin, et al., eds. 1986) and Whitehead, *Bowel Management in Children with Spina Bifida*, in *Spina Bifida: A Multidisciplinary Approach* 323, 329-30 (R. McLaurin, et al. eds. 1986).

¹⁶ She does not satisfy the criteria under listing 110.08 because spina bifida is compatible with life outside the womb and she will eventually be able to function above the level of a two-year old. She likewise fails the criteria under listings 111.06 and 111.08 because, at her age, the paralysis cannot be said to have interfered yet with "age appropriate major daily activities," although it significantly interferes with fine and gross motor development and will interfere with walking.

has deteriorated but rather because her *unchanged* level of impairment will be judged as meeting the listings.

Infants with spina bifida are not unique in being unable to demonstrate "medical equivalence" to one of the listed impairments. Some children are denied benefits because their particular clinical symptoms are so different from those in the listing that a finding of equivalence is highly unlikely, although as adults they would readily be able to show severe functional impairment.¹⁷

The Secretary's response to this fundamental criticism is twofold. First, he argues that "comparable severity" does not require identical treatment between children and adults. Pet. Br. 16, 24-25. Certainly, "comparable severity" does not on its face or in context require that children and adults be treated identically under the program. *Amici* agree with the Secretary's early understanding of the important differences that *should* be taken into account when assessing disability in children. A given impairment that disables a child from growing, developing and maturing might not disable an adult from engaging in substantial gainful employment. However, appropriate recognition of and allowance for the different manifestations of disabling impairments between adults and children does not in any way justify the Secretary's present regulatory scheme which prohibits

¹⁷ For example, the Part B listing contains one entry for esophageal impairment, restricted to conditions that involve narrowing of the esophagus and result in malnutrition (itself defined as 15 percent loss in weight or weight below the third percentile on standard growth charts). Listing 105.03 (J.A. 219). The listing fails to make any provision for additional esophageal disorders that afflict children, such as achalasia (failure of the muscles responsible for swallowing and peristalsis, see Berquist, et al., *Achalasia: Diagnosis, Management, and Clinical Course in 16 Children*, 71 *Pediatrics* 798 (1983)), and gastroesophageal reflux (muscle failure permitting gastric contents into the esophagus, with resulting damage to the esophagus and related pulmonary symptoms, including aspiration pneumonia, Jolley, et al., *Surgery in Children with Gastroesophageal Reflux and Respiratory Symptoms*, 96 *J. Pediatrics* 194 (1980)), although those disorders are equally disabling.

medical evaluations of comparable severity that are based on functional equivalence, unless the child's medical findings are strictly equal to the specific set of medical findings in a listed impairment. As previously discussed, this regulatory scheme results in grossly unequal treatment of children which is manifestly inconsistent with any plausible reading of the statutory term "comparable."

The Secretary's second response is that some imperfection in the system is not evidence of a systematic problem with the methodology the agency has chosen to implement Congress's directives. Pet. Br. 42. As to this point, the shortcomings of the present regulatory scheme for disability determinations of children involve more than a few outdated listings or a handful of excluded rare diseases. The imperfection in the scheme is systemic. By providing for additional steps for adults outside of the requirement that a claimant's impairment meets or equals a listed impairment, the Secretary has always silently acknowledged that a limitation of meeting or equaling a listed impairment, however complete a listing the agency was able to devise, would not satisfy Congress's directive to provide benefits to those who suffer from "any" impairment that prevents them from engaging in any substantial gainful activity. In light of this recognition of the inherent limitations in the listings applied to adults, it is difficult to comprehend how a slightly more expanded listing which a child must "meet or equal" can satisfy Congress's directive that children with impairments of "comparable severity" be found disabled, particularly when medical professionals know that children are much more likely to suffer from unusual disabling diseases and conditions than adults.

This latter point underscores another obvious flaw in the Secretary's argument about "comparable severity," namely that the term "comparable" on its face does not support a methodology that systematically underprotects children compared to adults. Ordinarily, "comparable" indicates that on occasion a child with a less severe medi-

cal condition than an adult nevertheless would receive disability benefits. But the Secretary's methodology requires all error to be on the side of denying benefits to children. Given the special needs of children, this approach is wholly irrational and should be rejected by this Court.

* * *

Amici do not underestimate the difficulty of administering a vast program such as Title XVI and they recognize the Secretary's need for establishing a solid base of objective criteria to permit uniformity in treatment of similarly afflicted individuals. Nevertheless, ease of administration cannot justify a regulatory system that in design and practice serves systematically to exclude from receiving benefits a substantial number of disabled children from low-income households on the sole basis that the technical medical findings of their physical or mental impairment fail to fit neatly into a limited number of boxes of specified signs, symptoms and findings. The medical profession does not treat patients as items in categories based strictly on diagnostic tests and symptoms and neither should the Secretary in deciding whether any medically determinable impairment is comparable to another. Instead, medicine considers functional ability in deciding what treatment to pursue and so should the Secretary of HHS in deciding whether benefits should be awarded. Despite the deference that is normally accorded an agency's interpretation of a statute which it administers, the present regulatory scheme for determining disability benefits for children under Title XVI is so clearly contrary to the statutory directive, the congressional intent and good medical practice that it cannot stand.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

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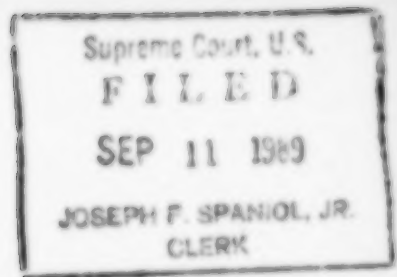
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No. 88-1377



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October Term, 1989

LOUIS W. SULLIVAN, Secretary of Health
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Petitioner

v.

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Respondents

**On Writ of Certiorari to the United States
Court of Appeals for the Third Circuit**

**BRIEF OF THE NATIONAL ORGANIZATION
OF SOCIAL SECURITY CLAIMANTS'
REPRESENTATIVES AS AMICUS CURIAE
IN SUPPORT OF THE RESPONDENTS**

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IN SUPPORT OF THE RESPONDENTS**

INTEREST OF AMICUS CURIAE NOSSCR

The National Organization of Social Security Claimants' Representatives (NOSSCR) is a non-profit corporation. While most of our members are attorneys in private practice, others work in programs which provide free legal services to the poor. Our members regularly represent people claiming disability benefits in administrative proceedings before the Social Security Administration of the U.S. Department of Health and Human Services (DHHS). Our members also file actions in federal court against the Secretary of DHHS ("the Secretary") appealing the final administrative denial of

clients' claims for such benefits. These disability benefits have been provided by the Congress through two separate but interrelated programs: Social Security Disability Insurance Benefits under Title II of the Social Security Act and Supplemental Security Income (SSI) under Title XVI of the Social Security Act. This case involves a special sub-group of claimants for SSI: indigent, disabled children.

Unfortunately the complexities of the qualifications for SSI, the labyrinthine nature of the administrative proceedings, and the frequent intransigence of DHHS — all of which are vividly demonstrated in this case — virtually require legal representation for these children. Moreover, the parents of these claimants, themselves indigent, are often ill-equipped from many standpoints to pursue their children's claims or even to aid their legal representatives in a meaningful way.

This brief is filed in a representational capacity on behalf of these special clients who, by virtue of their minority, indigency and disability, cannot speak for themselves. Our purpose is to draw to this Court's attention our nationwide experience that, notwithstanding its protestations, DHHS does not grant SSI benefits to indigent children suffering from impairments of "comparable severity" to those of adults who are granted benefits, despite the clear statutory mandate that SSI benefits be granted to such children. Further, this result is compelled by the regulations before the Court which, on their face, violate the Social Security Act.

SUMMARY OF ARGUMENT

Although the Congress has mandated that the Department of Health and Human Services grant Supplemental Security Income to impoverished children with impairments of comparable severity to those of adults granted benefits, the Secretary of DHHS has adopted regulations which compel a contrary result in many

instances. The child who is denied SSI often suffers the further adverse consequence of ineligibility for Medical Assistance even if such assistance would ameliorate the disabling condition.

At issue before the Court are the Secretary's SSI regulations which require that a child's impairment meet or equal one in the "Listing of Impairments," although adults need not meet such a requirement to be eligible. By comparison, an adult whose impairments do not meet or equal a Listing may be eligible for SSI if that adult's residual functional capacity is so limited that the individual is disabled. Indeed, some twenty-five per cent (25%) of all adults initially determined to be disabled by the Secretary are granted benefits on this basis without meeting or equaling a Listing.

Contrary to the Secretary's representations to this Court, the more stringent standards applied to children necessarily result in denial of benefits in comparable cases. Although some specific children's Listings do take functional consequences into account, unless a child's impairments meet or equal a Listing, the Secretary mandates that residual functional capacity be ignored and benefits be denied. Truncating the analysis of claims for child's SSI at the stage of meeting or equaling a Listing also denies to children the application of beneficial doctrines applied in adult cases such as the evaluation of disabling effects of pain and the "treating physician rule."

Disabled children are not treated comparably to adults with comparable impairments. This is best illustrated by those cases in which the Secretary denies SSI to disabled individuals when they are children and then grants them SSI as of their eighteenth (18th) birthday with no change whatsoever in the severity of their impairments. Because the Secretary's administrative procedures often drag out over the course of years, it is not unusual for NOSSCR members to represent children who become adults while their SSI claims are

pending. In many of these cases the Secretary grants SSI benefits effective the day of the claimant's eighteenth (18th) birthday. NOSSCR sets forth to this Court three examples of this arbitrary result of the challenged regulatory scheme. Younger children likewise suffer from the Secretary's illegally stricter treatment of them.

There is no justification for the Secretary's disparate treatment of children. Ignoring overall functional limitations of children who do not meet or equal a Listing necessarily results in the denial of claims which would be granted if the disabled individual were an adult. The Listings are not, and cannot be, comprehensive. They cannot determine the functional impact on all children of all disabling impairments. The Secretary argues that because children do not normally work, he cannot measure their functional capacity against any benchmark. Yet he acknowledges elsewhere that for children, disability is the impact of impairments on physical, mental and emotional growth and development. He is not, as he suggests, unable to make this determination for children on an individual basis. Indeed in one of the cases NOSSCR cites to this Court, that of Leon Gable, the Secretary determined a child to be functionally disabled at age thirteen (13), but because he found that child not to meet or equal a Listing, he refused to pay the child SSI.

It is no answer to suggest, as the Secretary does, that the courts should fill in any gaps in the Listings on an ad hoc basis on judicial review, by judicially constructing new and better Listings. To effectuate the statutory mandate that children be treated in a manner comparable to adults, the Secretary must be ordered to use comparable methodology in children's cases as in adults' cases. Otherwise indigent and disabled children will continue to be denied the SSI benefits created and intended for them by Congress.

ARGUMENT

I. THE SECRETARY'S SSI REGULATIONS RESULT IN THE DENIAL OF SSI TO MANY DISABLED CHILDREN WITH IMPAIRMENTS OF COMPARABLE SEVERITY TO THOSE OF ADULTS GRANTED SSI.

The nationwide experience of NOSSCR's membership demonstrates that the Secretary's regulatory interpretation of the children's Supplemental Security Income (SSI) Program is arbitrary, capricious and manifestly contrary to the enabling statute. In October 1972, Congress enacted Title XVI of the Social Security Act "establishing a national program to provide supplemental income to individuals who . . . are disabled . . . and are determined . . . to be eligible on the basis of . . . income and resources." P.L. 92-603, §§ 1601, 1602, 42 U.S.C. §§ 1381, 1381a. The SSI program specifically covers needy disabled children as well as adults:

An individual shall be considered to be disabled for purposes of this title . . . if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (*or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity*). (Emphasis added).

P.L. 92-603, § 1614(a) (3) (A), 42 U.S.C. § 1382c(a) (3) (A). The grant of SSI benefits to a needy disabled person is not only important for the limited federal monetary assistance¹ provided (currently \$368.00/month maxi-

1. States may provide a supplement to the federal payment. For example, Pennsylvania currently adds \$32.40 per month for a combined maximum total of \$400.40 per month. In some cases state supplements are mandatory; in other cases they are optional.

mum for an individual assuming no deductions for actual or deemed income),² but also because receipt of SSI normally makes an individual eligible for Medical Assistance (Medicaid) under Title XIX of the Social Security Act. 42 U.S.C. § 1396(a) (10)(A) (i). In many instances this Medical Assistance is even more valuable to the claimant than the cash assistance because it provides access to essential medical care. Denial of Supplemental Security Income may well cause denial of medical care needed to ameliorate a disabling condition.³

Under the Secretary's regulations, a disabled child can receive SSI benefits only if he or she has a medically determinable physical or mental impairment which is listed in the "Listing of Impairments," 20 C.F.R., Part 404, Subpart P, Appendix 1, or which is determined by DHHS to "medically equal" an impairment included in this Listing. 20 C.F.R. § 416.924. By comparison, an adult SSI applicant whose condition is not found to meet or equal one of those set forth in the Listings is *not* disqualified from benefits. Rather DHHS will go on to determine his or her overall residual *functional* capacity. This determination of residual functional capacity "is a medical assessment" of physical abilities, mental impairments and other impairments such as skin impairments, epilepsy, disorders of vision or hearing, manipulative

NOTES (Continued)

See 20 C.F.R. § 416.2001.

2. There are complicated rules by which part of the parents' income is "deemed" to be a child's, resulting in a reduction or loss of SSI benefits. See 20 C.F.R. §§ 416.1147, 416.1148, 416.1165, 416.1851. Hence SSI is only available to a disabled child whose family is indigent.

3. Indeed, it has been held that SSI is not available to an indigent child with pancreatic cystic fibrosis even though he needs federal benefits for preventative medication and treatment, where he does not meet the Secretary's regulations challenged here. *Burnside on behalf of Burnside v. Bowen*, 845 F.2d 587, 592 (5th Cir. 1988).

limitations, etc. 20 C.F.R. § 416.945(a). Then DHHS determines whether the adult claimant is disabled based upon that residual functional capacity, as well as age, education and work experience. 20 C.F.R. §§ 416.920, 416.945.

By contrast, DHHS makes no such assessment of the residual functional capacity of a child — and its disabling impact on the child — where DHHS finds that the child does not have a condition which meets or is "medically equal" to a Listing in the Listing of Impairments. The significance of terminating the analysis of children's disability claims at the stage of meeting or equaling the Listings is amply demonstrated by the Secretary's statistics for assessment of adult claims. Every year for the last five years, roughly 25% of all adults initially granted disability benefits did not meet or equal a Listing.⁴ These adults were granted benefits based upon the disabling impact of their residual functional capacity. No such assessment is made for children.

Moreover, the Secretary's definition of "medically equal" specifically excludes consideration of overall functional capacity:

As in determining whether the listing is met, it is incorrect to consider whether the listing is equaled on the basis of an assessment of *overall* functional impairment. The level of severity in any particular listing section is depicted by the given set of findings and not by the degree of severity of any single medical finding — no matter to what extent that finding may exceed the listed value.

The mere accumulation of a number of impairments also will not establish medical equivalence. When an individual suffers from a combination of

4. Appendix A to this brief is a Table provided by the Secretary to the Congress setting forth this data.

unrelated impairments, the medical findings of the combined impairments will be compared to the findings of the listed impairment most similar to the individual's most severe impairment. The functional consequences of the impairments (i.e., RFC), irrespective of their nature or extent, cannot justify a determination of equivalence. (Emphasis in original).

Social Security Ruling 83-19. Joint Appendix 236, 239-240.

The Secretary argues that:

Nor can it credibly be maintained that the Secretary's regulations are arbitrary and capricious. The criteria is the special Part B Listing for children in fact do take into account functional and developmental consequences of impairments and their impact on ability to do age-appropriate activities where those factors are germane to particular impairments. In other words, the considerations that respondents would require the Secretary to consider on an individualized basis were taken into account in the formulation of the Part B Listing in the first place. As a result, the criteria in the Listing *already* embody the level of impairment severity that, in the Secretary's judgment, has an impact on development in a child comparable to the impact of an impairment on an adult's ability to work. (Emphasis in original).

Brief for the Petitioner, p. 18. This is extremely misleading. It begs the question. Of course the Listings occasionally mention the functional consequences of impairments. But if an adult's impairments do not meet or equal one of the Listings, the Secretary then assesses his overall residual functional capacity. For a child this assessment is precluded by the Secretary's own interpretation quoted above.

Furthermore, the courts have imposed upon the Secretary the duty in adult SSI cases to consider a variety of factors not addressed by the Listing of Impairments. Two examples are the evaluation of disabling effects of pain and the "treating physician's rule." Section 223(d) (5) (A) of the Social Security Act provides, in relevant part:

An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue) must be considered in reaching a conclusion as to whether the individual is under a disability.⁵

42 U.S.C. § 423 (d) (5) (A). Nevertheless, the Adult Listings do not treat pain in any comprehensive manner,⁶ and the Childhood Listings do not specifically

5. This statutory provision is made applicable to SSI claims by 42 U.S.C. § 1382c(a) (3) (G).

6. Sections 1.05C and 7.16A of the Listings of Impairments for adults contain pain as one element of each Listing. There is nothing comparable in the parallel Listing of Impairments for children.

address pain at all. In order to fill this gap for adults, the courts have superimposed various rules regarding the evaluation of pain to effect this statutory mandate. The precedent in the Third Circuit is illustrative, requiring:

. . . (1) that subjective complaints of pain be seriously considered, even where not fully confirmed by objective medical evidence, *Smith v. Califano*, 637 F.2d 968, 972 (3d Cir. 1981); *Bittel v. Richardson*, 441 F.2d 1193, 1995 (3d Cir. 1971); (2) that subjective pain "may support a claim for disability benefits," *Bittel*, 441 F.2d at 1195, and "may be disabling," *Smith*, 637 F.2d at 972; (3) that when such complaints are supported by medical evidence, they should be given great weight, *Taybron v. Harris*, 667 F.2d 412, 415 n.6 (3d Cir. 1981); and finally (4) that where a claimant's testimony as to pain is reasonably supported by medical evidence, the ALJ may not discount claimant's pain without contrary medical evidence. *Green v. Schweiker*, 749 F.2d 1066, 1070 (3d Cir. 1984); *Smith*, 637 F.2d at 972.

Ferguson v. Schweiker, 765 F.2d 31,37 (3rd Cir. 1985).⁷ No comparable rules can be applied in claims for SSI for children because under the Secretary's challenged regulations disabling pain is simply not relevant.

Likewise, in adult disability claims, the courts have long enunciated the "treating physician rule" to the effect that:

. . . the expert opinion of a claimant's treating physician regarding his "medical disability, i.e. diagnosis and nature and degree of impairment, is . . .

NOTES (Continued)

Compare Part A and Part B of 20 C.F.R. Part 404, Subpart P, Appendix 1, set forth in the Joint Appendix pp. 115-235.

7. *Accord Polaski v. Heckler*, 751 F.2d 943, 948-950 (8th Cir. 1984); *Foster v. Heckler*, 780 F.2d 1125, 1129 (4th Cir. 1986).

binding on the fact-finder unless controverted by substantial evidence." *Schisler v. Heckler*, 787 F.2d 76, 81 (2d Cir. 1986).

Hidalgo v. Bowen, 822 F.2d 294, 296-7 (2nd Cir. 1987).⁸

The circuit courts have further adopted a "corollary" to the treating physician's rule, as follows:

A corollary to the treating physician rule is that the opinion of a non-examining doctor by itself cannot constitute the contrary substantial evidence required to override the treating physician's diagnosis. See *Havas*, 804 F.2d at 786; *Strickland v. Harris*, 615 F.2d 1103, 1109 (5th Cir. 1980); *Martin v. Secretary of Health, Education and Welfare*, 492 F.2d 905, 907-08 (4th Cir. 1974); *Landess v. Weinberger*, 490 F.2d 1187, 1190 (8th Cir. 1974); *Meffort v. Gardner*, 383 F.2d 748, 759 (6th Cir. 1967).

Id. at 297. Largely because the Secretary's analysis of SSI claims for children ends with the issue of whether a child meets or equals a Listing, the Secretary applies the converse of the "treating physician rule" in children's cases. 20 C.F.R. §416.926. As clearly set forth in Social Security Ruling 83-19:

Decisions of equivalence are the responsibility of a physician designated by the Secretary. In most instances, the designated physician is a physician in the State agency. A medical advisor at a hearing or a member of the Appeals Council's (AC) medical support staff (including medical consultants) may also make the physician's decision in the determination of medical equivalence.

As with any other medical opinion concerning impairment severity for titles II and XVI disability

8. *Accord Gilliland v. Heckler*, 786 F.2d 178, 184 (3rd Cir. 1986); *MacGregor v. Bowen*, 786 F.2d 1050, 1053 (11th Cir. 1986).

purposes, judgments of the examining physician are not controlling on the issue of equivalence. In every instance, the decision as to equivalence is to be made by a program physician based upon the individual medical findings in the particular case.

Joint Appendix at 240. Hence for children seeking SSI, the opinion of a non-examining physician on the ultimate issue of medical equivalence takes precedence over those of treating physicians, thereby turning the "treating physician rule" on its head.

II. MANY DISABLED INDIVIDUALS ARE DENIED SSI AS CHILDREN AND THEN GRANTED SSI AS ADULTS ON THEIR EIGHTEENTH BIRTHDAY WITH NO CHANGE IN THEIR IMPAIRMENTS.

In our practices, NOSSCR members repeatedly see that the inevitable effect of the Secretary's challenged regulation is to deny indigent disabled children SSI—and often therefore Medical Assistance—although their disabilities are of "comparable severity" to those of adults who would be granted benefits. This can best be seen in those cases in which a child turns eighteen (18) years old during the course of the notoriously lengthy administrative proceedings.⁹ It is not unusual for the Secretary to deny a child SSI disability benefits prior to her eighteenth (18th) birthday, but to award them as of that date. Because the child starts receiving monthly benefits and because this result is often mandated by the Secretary's challenged regulation, it is understandable that very few of these cases are appealed to court.

9. "The Secretary correctly points out that Congress repeatedly has been made aware of the long delays associated with resolution of disputed disability claims and repeatedly has considered and expressly rejected suggestions that mandatory deadlines be imposed to cure that problem." *Heckler v. Day*, 467 U.S. 104, 111 (1984).

A. Lisa Wills

One of the few reported court decisions involving this scenario is that of Lisa Wills. In *Wills v. Secretary of Health and Human Services*, the district court stated that the issue presented was whether Lisa Wills, then nineteen (19) years of age, suffered from problems which "were sufficiently disabling to entitle Lisa to SSI before her eighteenth birthday." 686 F. Supp. 171, 172 (W.D. Mich. 1987). The court noted that:

Lisa became eighteen during the administrative pendency of her SSI application. She was awarded benefits as an adult commencing on her birthday. That decision is not before the court.

Id. at 172, n.1. One unfamiliar with the Secretary's regulations might wonder what had befallen Lisa on her eighteenth birthday to render her condition so disabling as to be recognized as such by the Secretary. The simple answer is that all that befell Lisa was her eighteenth birthday and the application of the more flexible adult SSI regulations. In fact Lisa had suffered since infancy from a rare genetic enzyme defect which had caused mild retardation and central nervous system defect contributing to learning and behavioral difficulties. *Id.* at 172.

Lisa Wills was fortunate in that the reviewing court found that there was no substantial evidence to support the Secretary's finding that she did not meet a Listing as a child. The court therefore reversed the Secretary's final administrative decision denying her benefits. *Id.* at 176. Nevertheless her case demonstrates that, as the Secretary interprets and enforces his regulations, a child who is denied children's SSI may have the exact impairments which cause the Secretary to grant her adult SSI when she reaches the age of eighteen (18).

Lisa Wills' case is not an isolated example. Again and again we see similar situations of disabled children denied SSI benefits until their eighteenth birthday

(thereby frustrating the very purpose of the SSI children's program) and then granted SSI benefits as of their eighteenth birthday with no change in their impairments. Even for the few comparatively fortunate children like Lisa Willis who ultimately prevail in federal court, the Secretary's inflexible and arbitrary regulations mean the denial of SSI benefits during the critical period that they were intended to be received and often the consequent denial of Medical Assistance during that period.

B. Steven Martinez

Many disabled individuals and their families give up along the way, frustrated by the Secretary's seemingly interminable procedures and stymied by the double standard which the Secretary denies to this Court that he applies. The case of Steven D. Martinez exemplifies the Secretary's actual practice.¹⁰ Steven's mother filed an application for children's SSI benefits for Steven in early May 1985 alleging that he was disabled. Steven was then seventeen (17) years old. He suffered from severe bilateral sensorineural hearing loss and congenital abnormality of the right hand with severe loss of grip strength and absence of the right thumb and fourth and fifth fingers. In addition, he had received a penetrating injury to his rectum and bladder which necessitated surgery and a temporary colostomy. Steven's claim was denied initially and on reconsideration, and his mother requested a hearing before an administrative law judge. In June 1986, over thirteen (13) months after Steven's mother filed his claim, the administrative law judge issued a decision denying it.

On appeal, the Secretary acting through the Appeals Council remanded the case "for additional evaluation because the claimant had attained age eighteen (18) before the date of the decision." In October 1987, almost

10. Appendix B to this brief is a reproduced copy of the final "Favorable" decision in the Steven D. Martinez case.

two and a half years after the initial filing, Steven's claim was again denied by an administrative law judge. On appeal, the Secretary again remanded the case. A supplemental hearing was held in late October 1988, some three and a half years into the process. That hearing resulted in a final "favorable" decision on December 27, 1988.

The "favorable" decision in Steven Martinez' case again illustrates the illegality of 20 C.F.R. § 416.924. This final decision finds Steven to be disabled and eligible for SSI as of April 15, 1986, the day he turned eighteen (18), but not before.¹¹ No intervening injury or illness struck Steven on April 15, 1986. His impairments of April 15, 1986, were clearly of "comparable severity" to those he suffered in 1985 when he applied. Indeed if anything, his condition had improved by 1986 because he had had a longer recovery time since his temporary colostomy. When the Secretary's administrative law judge considered primarily the impact of his long-term hearing loss and congenital hand deformity, he appropriately found Steven's residual functional capacity to be so diminished that he was disabled as an adult. However, since none of Steven's impairments met a Listing, 20 C.F.R. § 416.924 barred him from receiving SSI as a child.

C. Leon Gable

Leon Gable was born on November 28, 1969, and suffers from defective intellectual development, the side effects of seizure medication (sluggishness, blurred vision and uncontrolled bowel movements), limited social ability and impaired ability to deal with stress. In December 1986, his mother filed an application for child's SSI benefits on his behalf. In July 1987, his mother also filed an application for "disabled adult child's" benefits

11. Steven took no further appeal of this partially favorable decision rendered over three and a half years after his application for benefits.

for Leon under Title II of the Social Security Act.¹² Both claims were denied initially and on reconsideration. Leon's mother sought and obtained a hearing before a Social Security administrative law judge. Almost two years after the child's SSI claim was filed, the ALJ issued a decision denying that claim, pursuant to 20 C.F.R. §416.924, finding that, "the evidence fails to establish conclusively a history of impaired intellectual functioning below that (I.Q. of 69 or less) prescribed by the Listings."¹³

However, with regard to Leon's claim for disabled adult child's benefits under Title II of the Social Security Act, the ALJ reached a different result, because only claimants for childhood SSI benefits are required to meet or equal a Listing. The ALJ considered the testimony of a "vocational expert" who had appeared at the hearing. This vocational expert testified that Leon was adversely affected by limited social awareness, limited social ability, poor ability to deal with stress, a history of seizures and impaired intellectual capacity. The vocational expert opined that an individual with Leon's combination of impairments was unlikely to function in any job. Using the standard for a disabled adult child, in which residual functional capacity is assessed, the ALJ found Leon to be under a disability since Sept. 1, 1983 (when he was 13 years of age). This entitled him to disabled adult child benefits after age 18, but not to SSI benefits as a child!

12. Ordinarily the child of a wage earner, who is entitled to old age or disability benefits or who has died, may receive benefits on that parent's account only until age 18. 20 C.F.R. §404.350. However, such a child may continue to receive Title II Social Security benefits on the parent's account past age 18, if the child has a disability that began before age 22. *Id.* This is a "disabled adult child."

13. Appendix C to this brief is the administrative law judge's decision of November 28, 1988, in the Leon Gable case.

On administrative appeal, the Secretary, acting through the Appeals Council, affirmed the decision of the administrative law judge, stating that he had correctly applied the law.¹⁴

NOSSCR could multiply examples from around the country of children who have been denied SSI benefits by the Secretary until the date of their eighteenth (18) birthday and granted benefits as of that birthday with no change in the severity of their impairments. However, we do not mean to suggest that 20 C.F.R. § 416.924 is illegal only with regard to this subgroup of children's SSI claimants who turn eighteen (18) during the Secretary's extended administrative processes. It is also illegally applied to young children who are denied children's SSI benefits who, we are confident, would have to be awarded benefits if their residual functional capacity were assessed in a manner comparable to that assessment for adult claimants. We specifically bring to this Court's attention the arbitrary and irrational results in the cases of children turning eighteen (18) because of the Secretary's own recognition of their disparate, non-comparable treatment, and not in any way to sanction the Secretary's illegal treatment of younger claimants.

III. THE REASONS ASSERTED BY THE SECRETARY FOR HIS DISPARATE TREATMENT OF DISABLED CHILDREN ARE NEITHER LAWFUL NOR RATIONAL NOR MANDATED BY PRAGMATIC CONCERNS.

The Secretary argues that "the concept of comparability does not rigidly require uniformity insofar as the subjects to be compared 'are different in a fundamental way.'" Brief for the Petitioner, p. 24. But surely the

14. Appendix D to this brief constitutes the Appeals Council's decision in the Leon Gable's case. Counsel of Record is advised that Leon Gable's attorney intends to file an appeal of the Secretary's decision to federal court.

statutory grant of benefits to children with impairments of comparable severity requires like results where there are identical impairments as in the cases cited above. Denial of childhood benefits in situations of comparable severity is the very essence of a regulatory framework that is arbitrary, capricious and manifestly contrary to the statute. *Atkins v. Rivera*, 477 U.S. 154, 162 (1986).

The Secretary further argues that the combined effect of multiple impairments is considered throughout the disability determination process. Brief for the Petitioner, p. 28, n.19. However, for children this process only extends to the determination of whether or not they have a severe impairment that meets or equals a specific listing. By the Secretary's edict, these combined effects will only be "compared to the findings of the listed impairment most similar to the individual's most severe impairment. The functional consequences of the impairments (i.e., RFC), irrespective of their nature or extent, cannot justify a determination of equivalence." SSR 83-19, Joint Appendix, p. 240. Hence, by the Secretary's regulations, Steven Martinez' functional limitations did not render him disabled for SSI purposes until he turned eighteen (18), then rendered him disabled.

Of course no listing of afflictions can ever be comprehensive, nor do all impairments necessarily impact all individuals in the same way. Indeed, as the Listings have been promulgated and revised, the Secretary previously acknowledged that they were not comprehensive and were not intended to preclude assessment of functional limitations in those cases where the Listings were not equaled or met. See *Marcus v. Bowen*, 696 F. Supp. 364, 373-376 (N.D. Ill. 1988).

The Secretary asserts:

The regulations focus, however, not on the individual child's ability to function as such, but on the impact of the impairment on his physical, mental,

and emotional growth and development. An assessment of functional abilities will normally be subsumed in applying these standards.

Brief for the Petitioner, p. 42. This self-contradictory language obfuscates rather than clarifies. If disability is not the impairment of function of an individual, what is it? In some cases, the child's impairment of physical, mental and/or emotional growth will be demonstrated by the child meeting or equaling a specific Listing. But because the Listings cannot be comprehensive, and because the overall functional consequences of impairments irrespective of their nature or extent cannot justify a determination of equivalence, the Secretary's regulation violates the Social Security Act.

The Secretary goes on to argue:

Simply put, an assessment of residual functional capacity or functional impairment cannot exist in a vacuum. The relevant question is, functional capacity to do *what*? With respect to adults, the Secretary is instructed to inquire into an individual's functional capacity to engage in "substantial gainful activity," i.e., to work. Ability to work thus provides a single, objective benchmark against which a person's individual non-medical attributes—his age, education, and previous work experience—can be assessed. As the Secretary has recognized from the outset of the program, however, the assessment of disability in children "cannot properly be associated with an inability to work, since children are not ordinarily expected to engage in such activity." J.A. 90. (Emphasis in original).

Brief for the Petitioner, p. 43. This is simply disingenuous. Obviously assessment of residual functional capacity or functional impairment cannot exist in a vacuum. But there is no mystery as to against what it should be assessed. The Secretary has acknowledged that the

appropriate issue is, as already noted, "the impact of the impairment on his [the child's] physical, mental and emotional growth and development." Brief for the Petitioner, p. 42. Indeed, since filing his Brief for the Petitioner with the Court, the Secretary has published a notice of proposed rulemaking which would revise the Listings of Impairments for children under age eighteen (18) with mental disorders. Federal Register, Vol. 54, No. 155, August 14, 1989, pp. 33238 *et seq.* In the new proposed mental Listings for children, the Secretary would evaluate various functional limitations "which are applicable to children," such as "motor development, cognitive/communicative function, and social function" and "function in the school setting." *Id.* at 33242.¹⁵ For the severely impaired child who does not meet or equal a Listing, an assessment of limitation of function in these areas is essential to determine whether that child has impairments of comparable severity to those of adults who would be granted benefits.

As the Leon Gable case exemplifies, the Secretary can apply functional criteria to children who do not meet or equal the Listings. Using this criteria, the Secretary found Leon to be disabled at age 13. The Secretary is not unable to apply comparable criteria, but rather is unwilling to award SSI benefits to comparably impaired children.

The Secretary opines:

Moreover, as noted above, if, as respondents allege, there are any "gaps" in the Secretary's Part B Listing (Br. in Opp. 24)—that is, if experience reveals that

15. While these proposed regulations, if adopted, would certainly be an improvement over the current children's mental Listings, they would not resolve this case. The Secretary still would not assess the overall residual functional capacity of children whose mental impairments do not meet or equal a specific mental Listing; and the new Listings would not apply to children whose impairments are primarily physical.

the Listing overlooks certain impairments that have a severe impact on childhood growth and development, or inadequately gauges the impact of a specific impairment on childhood development—the solution is not to jettison the entire regulatory framework. Rather, as the district court observed, the proper remedy is to challenge particular Part B listings (or the absence of such listings) on judicial review of the denial of disability benefits.

Brief for the Petitioner, p. 42. Respondents are not seeking "to jettison the entire regulatory framework" and have not asked the courts to do so. Rather, because there are, and must be, gaps and inadequacies in any set of Listings, respondents ask that the Secretary be ordered to apply an assessment of residual functional capacity to children whose impairments do not meet or equal one of the Listings in a manner comparable to that assessment for adults.

The Secretary's argument regarding the challenge to particular Listings or the absence thereof is not only unrealistic, but is a complete misstatement of what the district court said. The district court never suggested that an appellant could challenge a particular Listing or absence thereof on judicial review. Rather, it stated:

Plaintiffs' argument may well be valid, in many cases; but errors in applying the regulations in some cases do not demonstrate invalidity of the regulations themselves. Part B of the Secretary's listings of impairments, 20 C.F.R. § 416.925, is not facially invalid or incomplete, seems to provide the necessary flexibility, and, in my view, permits the award of benefits in conformity with the intent of Congress. If these criteria are being misapplied or misinterpreted, the remedy lies in the appeal process in individual cases, not in a class-action decree.

Zebley v. Heckler, 642 F. Supp. 220, 222 (E.D. Pa. 1986).

The reality is that such an attack on the adequacy or non-existence of a specific Listing would likely be precluded by the courts' limited scope of review. The standard for judicial review of the denial of individual claims is set forth in Section 205(g) of the Social Security Act, 42 U.S.C. § 405(g), which provides in relevant part:

The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Secretary, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations.

Applying this test to Social Security appeals, this Court has stated that substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971). As the Secretary correctly notes, Congress has given him authority to publish such criteria as Listings. Brief for the Petitioner, p. 21. A direct attack on a specific Listing or lack thereof would implicate the courts in what the Secretary claims is implicated here: substituting their medical judgment for that of the Secretary. The Secretary points to no case in which such an attack has been mounted, much less one that has been successful. One can imagine the Secretary's reaction if, on judicial review, one were to ask a court, for

example, to rule that the standard for growth impairment under Listing 100.03A should be a drop in height of 20 percentiles rather than the current regulatory 25 percentiles. See Joint Appendix, p. 208. He would, properly, respond that such a judgment is his, not the court's, to make.

One cannot expect the courts to substitute their medical judgment for that of the Secretary. Nor is the answer to ask the courts to do so, on an individual basis, to remedy gaps and flaws in the Listings. Rather, the answer is for this Court to direct the Secretary to use comparable methodology to assess children's impairments as he does to assess adults' impairments. That is the only way to effectuate Congress' clear mandate that the Secretary grant SSI benefits to children who suffer from any medically determinable physical or mental impairment of comparable severity to that of an adult who would be granted such benefits.

CONCLUSION

Congress has clearly and specifically mandated that the Department of Health and Human Services grant SSI benefits to children who suffer from any medically determinable physical or mental impairment of comparable severity to that of an adult who would be granted such benefits. Instead the Secretary of DHHS holds children to a more restrictive standard of disability than adults, by requiring them to present an impairment that meets or equals a Listing and by ignoring impairment of their overall residual functional capacity. The necessary result of this disparate treatment is to deny SSI and Medical Assistance to many of the children whom Congress intended to benefit from these programs. The Secretary's arguments that children are treated in a comparable manner to adults ignore the inevitable results of this regulatory framework and are belied by his actions. The arbitrary and capricious results are not

mandated by any inability to perform the evaluations mandated by Congress. Real children in real need with real and serious problems suffer real harm as a result. These children will not receive the statutory benefits they desperately need unless and until this Court upholds the Third Circuit and directs the Secretary to make fully comparable assessments of the impairments of disabled children.

Respectfully submitted, ;

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APPENDIX

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**COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES**

**BACKGROUND MATERIAL AND DATA
ON PROGRAMS WITHIN THE
JURISDICTION OF THE
COMMITTEE ON WAYS AND MEANS**

1989 EDITION



MARCH 15, 1989

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TABLE 2.—BASIS FOR TITLE II ALLOWANCES—
NATIONAL FIGURES: INITIAL
WORKER DETERMINATION,
FISCAL YEARS 1975-88
IN PERCENT

Fiscal Year	Meets listing	Equals listing	Medical and vocational considerations
1975.....	29.4	43.9	26.7
1976.....	29.0	45.1	25.9
1977.....	34.2	41.9	23.9
1978.....	45.6	31.9	22.5
1979.....	55.1	22.7	22.1
1980.....	57.9	16.2	25.9
1981.....	63.9	12.3	23.8
1982.....	72.7	8.6	18.7
1983.....	74.0	8.3	17.7
1984.....	66.7	8.7	24.6
1985.....	62.7	9.2	28.1
1986.....	68.2	8.7	23.1
1987.....	66.0	10.2	23.8
1988.....	64.3	11.0	24.7

Source: Office of Disability, Social Security Administration.

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration
OFFICE OF HEARINGS AND APPEALS

DECISION

IN THE CASE OF: CLAIM FOR:
Steven D. Martinez Supplemental Security Income

(Claimant) _____

OMITTED
(Social Security Number)

Section 1614 of the Social Security Act, 20 CFR 416.901-416.999, and Appendices 1-2, Subpart P, Regulations No.4 (Code of Federal Regulations) provide the definition of "disability" that is being applied in this administrative decision.

The claimant in the instant case is a twenty year old man who has a tenth grade education and no past relevant work experience. His mother, Sylvia Martinez, filed an application for Title XVI supplemental security income on the claimant's behalf on May 3, 1985, and alleged therein that he had been disabled since July 1980 because of a hearing impairment and a colostomy (Exhibit 1). His claims were denied at both the initial and reconsideration levels. Dissatisfied with those determinations, the claimant filed a timely request for hearing on December 5, 1985 (Exhibit 10). This request for hearing resulted in a denial by an Administrative Law Judge on June 25, 1986 (Exhibit 21). On appeal, the Appeals Council remanded the case for additional evaluation because the claimant had attained age eighteen before the date of the decision. This remand resulted in another denial decision issued on October 26, 1987. The

case was again appealed and has currently been remanded for consideration of the period prior to the claimant's attainment of age eighteen and after the attainment of age eighteen. It was also ordered that a vocational expert provide testimony at the hearing regarding the impact of the claimant's nonexertional impairments on his ability to perform light and sedentary work. A supplemental hearing was held on October 26, 1988, in Pueblo, Colorado. The claimant appeared personally at the hearing, and was represented by Trudie Gilmore, a non-attorney representative. Present to testify as a vocational expert was Dr. Raymond Best.

ISSUES

The issue before the Administrative Law Judge is whether the claimant is disabled under section 1616(a)(3)(A) of the Social Security Act. The Act defines "disability" as the inability to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment(s) which can be expected to either result in death or last for a continuous period of not less than twelve months or, in the case of a child under the age of eighteen, if he or she suffers an impairment of comparable severity.

EVALUATION OF THE EVIDENCE

Section 416.920 of Regulations No. 16 provides, that in assessing an individual's allegations of disability, a sequential evaluation method will be used. Current work activity, severity of impairments and vocational factors are considered in that order. However, if a determination can be made at any stage that an individual is, or is not, "disabled", evaluation under a subsequent step shall be unnecessary. Section 416.923 of the Regulations provides that a child under age eighteen is disabled if he (a) is not doing any substantial gainful activity; and (b) has

a medically determinable physical or mental impairment(s) which meets the duration requirement, is listed in Appendix 1 of Subpart P of Regulations No. 4, or is determined to be medically equal to an impairment listed.

Neither the testimony at the hearing nor the documents in the file indicate that the claimant has ever engaged in any substantial gainful activity. Therefore, a finding cannot be made at Step 1 of the Sequential Evaluation of the Evidence under Regulations 416.920(b). The undersigned must next determine whether the claimant is suffering from a severe impairment or combination of impairments which would meet or equal the requirements of the Listings of Impairments at Appendix 1 to Subpart P of Regulations No. 4.

As previously discussed, prior to the attainment of age eighteen, and in order to qualify for supplemental security income, the claimant would have to have a listing level impairment. Vocational factors, age, education, or skill level of work experience are not taken into consideration until the attainment of age eighteen. After the attainment of age eighteen, the sequential evaluation regulations apply to the evaluation of the claimant's condition; and then vocational factors are considered. The medical evidence reveals that the claimant has a significant bilateral sensorineural hearing loss documented by audiograms in May 1985, July 1985, and March 1986 (Exhibits 15, 17, 18, and 19). It was the claimant's testimony at the hearing that he wears a hearing aid, but has had difficulty finding one that works well for him. At the time of the hearing, he was anticipating trying yet another hearing aid, in hopes that he would be able to hear better. In his left ear, he has no hearing whatsoever. He described having difficulty hearing when there are many people in the room or background noise. In these situations, the claimant described that he mostly does lip reading. He has difficulty using the telephone and does not feel safe

driving for long distances. It is clear that this impairment is imposing some work-related restrictions, and therefore, would be a "severe" impairment. However, his hearing impairment is not as severe as that required by section 2.08 of the Listing of Impairments. The claimant's pure tone average loss in the better ear is 30db and the SRT is 35db which indicates that he has the potential for gain from amplification. With a hearing aid, he would have a 56 percent discrimination. Section 2.08 of the Listing of Impairments requires speech discrimination of 40 percent or less. Clearly, the claimant would have difficulty in any situation where keen hearing was required or in a noisy or public setting, or where he had to use the telephone to any extent. However, his hearing loss cannot be found to be of listing level severity either prior to or after the attainment of age eighteen, and continuing through the present.

The claimant also alleges a degree of disability secondary to a congenital abnormality of his right hand. He cannot fully use the right upper extremity and his ability to lift, carry, or manipulate is impaired. The claimant estimated that he can only lift five pounds at a time. The claimant's treating physician, Dr. Villalon reported in May 1987 that the claimant's deformity resulted in a severe loss of grip strength. The right thumb, fourth and fifth fingers are absent. Section 1.09 of the Listings of Impairments governs the evaluation of disability secondary to amputation or anatomical deformity resulting in residual limitation. However, this listing requires that the amputation be present in both hands, both feet, or one hand and one foot. Since the claimant is missing three fingers from only one hand, it is clear that this impairment is not of listing level severity. This condition has not been of listing level severity at any time prior to the date of this decision, including the period of time prior to the attainment of age eighteen.

At this most recent hearing, the claimant alleged that he experiences back pain on a daily basis, for which he takes Darvocet. He described that he takes this medication every day for back pain and that he has a great deal of difficulty standing for more than twenty minutes at a time. He could not bend more than three to four times throughout the day. The medical record is silent regarding any mention of a back impairment. The claimant was examined by an orthopedist, Dr. Hamill, in August 1985 (Exhibit 18), mostly in connection with the deformity of his right hand. However, Dr. Hamill noted that with respect to the claimant's neck, spine, lower extremities, and left upper extremities, all findings were within normal limits. There certainly has been no indication of any radiculopathy or neurological deficits as required by Section 1.05(C) of the Listings of Impairments which governs the evaluation of disability secondary to disorders of the spine. The claimant's back impairment has never been of listing level severity, neither prior to the attainment of age eighteen, nor since.

Finally, the claimant alleges a degree of disability secondary to residual impairment following a penetrating injury to his rectum and bladder which occurred in February 1985 (Exhibits 11 and 12). The claimant underwent exploratory surgery for repair of his bladder and colon, and had a temporary colostomy until June 1985. Since then, the claimant alleges that he has continued to experience intermittent pain and discomfort in the colostomy area as well as periodic diarrhea and gas. At the most recent hearing, the claimant reported that he is not taking any regular medication for this impairment, but occasionally requires Pepto Bismol. He has not been able to seek treatment for these residual complications due to a lack of funds. He testified that he vomits once or twice a day in connection with his abdominal impairments. Since the claimant has not sought treatment for these residual symptoms, there is

no medical documentation of clinical findings which would indicate an impairment which meets or equals any of the Listings of Impairments at Section 5.01, which pertains to the digestive system. There have been no instances of obstruction, abscess, fistula, or stenosis. The claimant has not experienced any severe weight loss because of this problem; on the contrary, he has gained weight and is considered to be obese. In order for the claimant's obesity to be found to be of listing level severity, at his height, he would have to weigh 310 pounds. Currently, the claimant testified that he weighs 270 pounds, and it is clear that his obesity is not of listing level severity, nor was it of listing level severity prior to the attainment of age eighteen.

Since none of the claimant's impairments are of listing level severity, it cannot be found that he was disabled and entitled to supplemental security income at any time prior to the attainment of age eighteen. Regarding the period since the attainment of age eighteen, the undersigned must now proceed to determine whether the claimant retains the capacity to perform any work which exists in significant numbers in the regional or national economies. Once a claimant has established that he cannot perform his past relevant work or that he has no past relevant work, the burden shifts to the Secretary to show that there are other jobs existing in significant numbers in the national economy which he can perform, consistent with his medically determinable impairments, functional limitations, age, education, and work experience. On an exertional basis, giving the claimant the benefit of the doubt, and allowing for some significant pain and discomfort when lifting, the undersigned concludes that exertionally, the claimant would be limited to lifting no more than five pounds at a time with his right hand and twenty pounds at a time with both hands, due to the residual effects (pain, discomfort, periodic diarrhea, stomach gas, and vomiting) of his rectal and bladder injuries. Even allowing for some

discomfort in the claimant's lower back, the claimant could not be expected to lift more than twenty pounds at a time. From an exertional standpoint, the Administrative Law Judge therefore finds that the claimant retains a residual functional capacity for the performance of a wide range of at least "light" work. Light work as defined by Social Security Regulations requires lifting no more than ten pounds on a repetitive basis and twenty pounds occasionally. It requires an ability to stand and walk for up to six hours out of an eight hour day.

The ability to perform light work also includes the ability to perform sedentary work. Most unskilled sedentary jobs required good use of the hands and fingers for repetitive hand-finger actions. Furthermore, many of the jobs at these exertional levels require a keen sense of hearing. A vocational expert was present at the hearing to assess the degree of impact upon the claimant's maximum sustained work capability imposed by his nonexertional impairments. Dr. Best testified that given the claimant's hearing problems and his manipulative deficits in the right hand, that there would be a significant erosion upon the vocational base of jobs existing at the unskilled sedentary or light level.

At twenty years old, the claimant is currently considered to be a younger individual. He has a high school education and no past relevant work experience. If the claimant had the capacity to perform the full range of light work activity, his medical-vocational profile would coincide with all the factors of Rule 202.20, which directs a determination of "not disabled". However, when a claimant suffers nonexertional impairments, these rules may only be used as a framework for decision making. In this case, great weight has been accorded to the testimony of the vocational expert which indicates that the claimant's nonexertional limitations in the areas of hearing and manipulating with his right hand preclude the performance of so many jobs at the sedentary or light unskilled level, that jobs the claimant might be

able to perform would no longer exist in significant numbers in the regional or national economies. Accordingly, pursuant to 20 CFR 416.920(f), the claimant is found "disabled", as of the date he attained age eighteen, April 15, 1986, but not prior thereto.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant has never engaged in substantial gainful activity.
2. The medical evidence establishes that the claimant suffers from sensorineural hearing loss, deformity of the right hand, status/post colostomy closure, obesity, and lower back pain.
3. The medical evidence further establishes that the claimant does not have an impairment or combination of impairments either listed in or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4 (20 CFR 416.925 and 416.926).
4. The claimant was not under a "disability" as defined in the Social Security Act, at any time prior to the attainment of age eighteen (20 CFR 416.923).
5. The claimant's testimony and demeanor at the hearing regarding the extent of his pain and functional limitation was found to be completely credible and convincing.
6. The claimant has the residual functional capacity to perform physical exertion and nonexertional requirements of work except for lifting twenty pounds on an occasional basis with both hands, lifting more than five pounds on an occasional [sic] basis with the right hand, standing and/or walking more than six hours out of an eight hour day; asks requiring good grip strength or dexterity of the right

hand; or working in environments with background noise or a large degree of telephone usage (20 CFR 416.945).

7. The claimant has no past relevant work experience.

8. The claimant's functional capacity for the full range of light work is reduced by nonexertional limitations (hearing impairment and deformity of the right hand).

9. The claimant is twenty years old, which is defined as a younger individual (20 CFR 416.963).

10. The claimant has a high school education (20 CFR 416.964).

11. The claimant does not have any acquired work skills which are transferrable [sic] to the skilled or semi-skilled work activities of other work (20 CFR 416.968).

12. Based on an exertional capacity for light work, and the claimant's age, education, and lack of work experience, Section 416.969 of Regulations No. 16 and Rule 202.20, Table No. 2, Appendix 2, Subpart P, Regulations No. 4 would direct a conclusion of "not disabled".

13. Considering the claimant's additional non-exertional limitations within the framework of the above-cited rule, he cannot be expected to make a vocational adjustment to work which exists in significant numbers in the national economy.

14. The claimant has been under a "disability" as defined in the Social Security Act, since April 15, 1986, the date he attained age eighteen (20 CFR 416.920(f)).

DECISION

It is the decision of the Administrative Law Judge that, as of the date the claimant attained age eighteen, April 15, 1986, the claimant was "disabled" under Section 1614(a)(3)(A) of the Social Security Act, and that the claimant's disability has continued through at least the date of this decision.

The component of the Social Security Administration responsible for authorizing supplemental security income payments will advise the claimant regarding the non-disability requirements for these payments, and if eligible, the amount and month(s) for which payment will be made.

RICHARD B. PAYNTER
Administrative Law Judge

December 27, 1988

Date

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration
OFFICE OF HEARINGS AND APPEALS

DECISION

<u>IN THE CASE OF:</u>	<u>CLAIM FOR:</u>
	Child's Insurance
	Benefits (Disability and
	Supplemental Security Income
<u>Leon C. Gabel</u>	<u>(Child)</u>
(Claimant)	
	OMITTED (Claimant)
<u>Leon N. Gabel</u>	<u>OMITTED (Wage Earner)</u>
(Wage Earner)	(Social Security Number)

PROCEDURAL HISTORY

The claimant's mother, Monica Gabel, filed an application for child's supplemental security income benefits on the claimant's behalf. This claim was denied through the hearing level. After a review by the Appeals Council the prior denial was vacated and the undersigned was instructed to issue a new decision.

Pursuant to the Appeal's Council directive, a psychological examination, psychiatric examination and neurological examination were scheduled. The reports of these examinations were proffered to the claimant's representative and entered into the record. Additionally, a hearing was held at which time the undersigned obtained testimony from Paul Salamone, an independent vocational expert. Additional evidence was also received from the claimant's representative and entered into the record.

The claimant's mother also filed an application for disabled adult child's benefits on July 2, 1987. The claimant attained the age of 18 on November 28, 1987.

This is escalated to the hearing level and I am issuing a decision on both the application for child's supplemental security income and also the application for disabled adult child's benefits.

ISSUES

The issue before the Administrative Law Judge is whether the claimant is disabled under Section 1614(a)(3)(A) of the Social Security Act. The Act defines "disability" as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to either result in death or last for a continuous period of not less than 12 months or, in the case of a child under the age of 18, if he or she suffers from any medically determinable impairment of comparable severity.

An additional issue is whether the claimant is entitled to child's insurance benefits (disability) under Section 202(d) of the Social Security Act, as amended. The specific issue is whether the claimant is under a "disability," as defined in Section 223(d) of the Act, which began prior to the date the claimant attained age 22.

APPLICABLE REGULATIONS AND EVALUATION OF THE EVIDENCE

Pursuant to the Act, the Secretary has established Social Security Administration Regulations No. 16. Section 416.924 of the regulations provides that a child under age 18 is disabled if he or she (a) is not doing any substantial gainful activity; and (b) has medically determinable physical or mental impairment(s) which compare(s) in severity to any impairment(s) which would make an adult (a person age 18 or over) disabled. This requirement will be met when the impairment(s) —

- (1) Meets the duration requirement; and

- (2) Is listed in Appendix 1 of Subpart P of Regulations No. 4; or

- (3) Is determined to be medically equal to an impairment listed in Appendix 1 of Subpart P of Regulations No. 4.

The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity. The Listing of Impairments consists of Parts A and B. In evaluating disability for a person under age 18, Part B will be used first. If the medical criteria in Part B do not apply, then the medical criteria in Part A will be used.

Pursuant to the Act, the Secretary has established Social Security Administration Regulations No. 4. The regulations provide steps for evaluating disability (20 CFR 404.1520(a)). In addition, a claimant's impairment must meet the 12-month duration requirement before being found disabling. A set order is followed to determine whether an individual is disabled. *If it is determined that a claimant is or is not disabled at any point in the review, further review is not necessary.*

Social Security Administration Regulations No. 4 requires the Administrative Law Judge to consider the following in sequence:

1. An individual who is working and engaging in substantial gainful activity will not be found to be "disabled" regardless of medical findings (20 CFR 404.1520(b));

2. An individual who does not have a "severe impairment" will not be found to be "disabled" (20 CFR 404.1520(c));

3. If an individual is not working and is suffering from a severe impairment which meets the duration requirement and which "meets or equals a listed impairment in Appendix 1," Part A or Part B,

of Subpart P of Regulations No. 4, a finding of "disabled" will be made without consideration of vocational factors (20 CFR 404.1520(d));

4. If an individual has worked and is capable of performing work he or she has done in the past, a finding of "not disabled" must be made (20 CFR 404.1520(e));

5. If an individual's impairment is so severe as to preclude the performance of past work, other factors including age, education, past work experience and residual functional capacity must be considered to determine if other work can be performed (20 CFR 404.1520(f)).

The rules set out in Appendix 2 of Subpart P of Regulations No. 4 will be considered in determining whether a claimant with exertional impairments is or is not disabled. The regulations also provide that if an individual suffers from a nonexertional impairment as well as an exertional impairment, both are considered in determining residual functional capacity (20 CFR 404.1545). The rules established in Appendix 2 are then used as a framework in evaluating "disability," if a finding of disabled cannot be made based on strength limitations alone. In cases where the individual has solely a nonexertional type of impairment, determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2.

DECISION

The evidence of record fails to demonstrate that the claimant's impairments considered singly or in combination meet or equal the Listing of Impairments. Therefore it is concluded that the claimant does not meet the

standards for eligibility for child's supplemental security income benefits.

The evidence demonstrates that there are no jobs existing in significant numbers which the claimant can perform. Therefore he is eligible for disabled adult child's benefits.

RATIONALE

In order for a child to be determined under a disability under Title XVI, his impairment must be listed in the Listing of Impairments of Appendix 1, Subpart P of Regulations No. 4 or singly or in combination must be the equivalent of a listed impairment. Generally speaking, the Listing of Impairments is a detailed listing divided by body systems into sections of specific diseases and abnormalities in prescribing types of test results and other data required to support a finding of "disability".

Listing 112.05 requires that the claimant have an I.Q. of 60 to 69 inclusive, and physical or other mental impairment imposing additional and significant restriction of function or development progression.

Psychological testing in September 1983 when the claimant was 13 years old demonstrated a Verbal I.Q. score of 78, a Performance I.Q. score of 71 and a Full-Scale I.Q. score of 72 (Exhibit 11).

Testing on June 2, 1986 when the claimant was 16 years of age, showed a Verbal I.Q. score of 69, a Performance I.Q. score of 78 and a Full-Scale I.Q. score of 72. He functioned in the upper area of the educable mentally retarded range (Exhibit 11).

The psychological testing requested by the Appeals Council directive was performed on August 9, 1988 by psychologist Richard Pearson. This demonstrated a Verbal I.Q. score of 76, a Performance I.Q. score of 81 and a Full-Scale I.Q. score of 77. His overall conclusion was that the claimant would be a candidate for a carefully

managed work setting, appropriate to his limited intellectual resources (Exhibit 22).

In the opinion of consulting psychiatrist, Sherwin Radin, M.D., the claimant's mental retardation/borderline intelligence would make it difficult for him to work in many settings but he "... should be able to do some kind of work" (Exhibit 23).

The evidence fails to establish conclusively a history of impaired intellectual functioning below that (I.Q. of 69 or less) prescribed by the Listings. Dr. Monreal found no additional significantly limiting neurological deficits (Exhibit 25). Dr. Radin concluded that the claimant's psychological condition would make it difficult, but not impossible, to perform work activity (Exhibit 23), a conclusion which is not rebutted by psychologist Person's testing (Exhibit 22).

Since the evidence of record failed to demonstrate that the claimant's condition meets or equals the Listing of Impairments, the undersigned concludes that the claimant does not meet the standards for eligibility for child's supplemental security income benefits within the meaning of Title XVI of the Social Security Act.

Since it is concluded that the claimant's condition does not meet or equal in severity the requirements of the Listings, in order for the claimant to be found eligible for disabled adult child's insurance benefits under Title II of the Act, the evidence must show that the claimant is unable to perform his past relevant work or any other substantial gainful activity. The claimant has no past relevant work experience. Hence, the issue before the undersigned is whether there are jobs existing in significant numbers which a person such as the claimant can perform.

In order to develop the record more fully an independent vocational expert, Dr. Paul Salamone, was asked to testify whether a person such as the claimant could engage in any substantial gainful activity. His testimony indicated that the claimant has the following

adverse vocational factors: limited social awareness, limited social ability, poor ability to deal with stress, a history of seizures and impaired intellectual capacity. In his opinion it was unlikely that such a person could function in any job.

In view of the claimant's history of defective intellectual development since September 1, 1983 (Exhibit 11, page 4), the opinion of psychologist Merick, the side effects of his seizure medication (sluggishness, blurred vision and uncontrolled bowel movements), the claimant's limited social ability and his impaired ability to deal with stress, it is concluded that he has been precluded from performing any substantial gainful activity. It is concluded that he is entitled to child's insurance benefits (disability) under Section 202(d) of the Social Security Act.

There is evidence to suggest that with rehabilitative efforts Mr. Gabel can be trained to work and he is encouraged to avail himself of the opportunity to do so.

Because of his young age and potential for rehabilitation, his continued entitlement to benefits should be periodically reviewed.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant is the child of the wage earner, Leon C. [sic] Gabel.
2. The claimant was unmarried at the time that his application for disabled adult child's insurance benefits was filed and is still unmarried.
3. The claimant was dependent on the wage earner.
4. The claimant attained the age of 18 on November 28, 1987.

5. The claimant has never engaged in substantial gainful activity.

6. The claimant has the following impairments: borderline intellectual functioning, a seizure disorder (In control with medication).

7. The claimant has no past relevant work experience.

8. The medical evidence establishes that the claimant does not have an impairment or combination of impairments listed in or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4.

9. There are no jobs existing in significant numbers which a person such as the claimant could perform.

10. The claimant has been under a "disability" as defined in the Social Security Act, since September 1, 1983 which is prior to the date the claimant will attain the age of 22.

DECISION

It is the decision of the undersigned Administrative Law Judge that, based on the application filed on December 2, 1988, the claimant is not eligible for supplemental security income under Section 1602 and 1614(a)(3)(A) of the Social Security Act.

It is the decision of the Administrative Law Judge that, based on the application filed on July 2, 1987, the claimant is entitled to child's insurance benefits (disability) under Sections 202(d) of the Social Security Act.

Joachim J. Volhard
Administrative Law Judge
Office of Hearings and Appeals
Suite 400, The Chambers
351 South Warren Street
Syracuse, New York 13202-2056

Dated: November 28, 1988

**DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration
OFFICE OF HEARINGS AND APPEALS
DECISION OF APPEALS COUNCIL**

IN THE CASE OF:

Leon C. Gable

(Claimant)

CLAIM FOR:

Supplemental Security Income
(Child) and Supplemental
Security Income

OMITTED

(Wage Earner)
(Leave blank if same as above)

(Social Security Number)

This case is before the Appeals Council on the claimant's request for review of the Administrative Law Judge's decision dated November 28, 1988, as it pertained to the claimant's child's supplemental security income claim. By letter dated May 31, 1989, the claimant and his representative were advised that the Appeals Council had granted his request for review and proposed, absent new and material evidence or legal argument to the contrary, to issue a decision finding him "not disabled" with respect to the child's supplemental security income claim, but, "disabled" under section 1614(a)(3)(A) of the Social Security Act.

The Appeals Council has considered the entire record which was before the Administrative Law Judge. The Appeals Council's notice of review has been entered into the record as Exhibit AC-1. There has been no response to this notice received from the claimant and/or his representative.

The Administrative Law Judge's statements as to the pertinent provisions of the Social Security Act, the issues in the case, and the evidentiary facts are incorporated herein by reference.

On November 28, 1988, the Administrative Law Judge issued a decision finding the claimant "disabled" with respect to his claim for disabled child's benefits. The decision found the claimant did not meet the standards for eligibility for child's supplemental Security income benefits. It was this portion of the Administrative Law Judge's decision that the claimant requested Appeals Council review.

With regard to child's supplemental security income benefits, if the claimant is under age 18, we will consider him disabled if he is suffering from any medically determinable physical or mental impairment(s) which compares in severity to an impairment that would make an adult (a person age 18 or over) disabled. This requirement will be met when the impairment(s) —

- (1) Meets the duration requirement; and
- (2) Is listed in Appendix 1 of Subpart P of Part 404; or
- (3) Is determined by us to be medically equal to an impairment listed in Appendix 1 of Subpart P of Part 404 (20 CFR 416.924).

The Administrative Law Judge in his decision found the claimant did not have an impairment(s) which met these requirements. After a careful review of all the evidence of record, the Appeals Council concurs with the Administrative Law Judge on this finding.

Once a person reaches the age of 18, the standard used to define disability changes. Now, the law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (20 CFR 416.905). This is the same standard used by the

Administrative Law Judge in finding the claimant disabled with respect to his claim for disabled adult child's benefits.

On November 28, 1987, the claimant attained the age of 18. Therefore, at that time, the issue of disability was the same as had already been decided under a different title of the Act. When this happens, the issue will not be considered again, but we will accept the factual finding made in the previous decision unless there are reasons to believe it was wrong (20 CFR 416.1450(f)).

In view of the above, the Appeals Council finds that prior to the claimant's attainment of age 18, he was not eligible for child's supplemental security income. However, as of November 28, 1987, the Appeals Council finds the claimant "disabled" under section 1614(a)(3)(A) of the Social Security Act.

DECISION

It is the decision of the Appeals Council that, based on the application filed on December 2, 1986, the claimant is not eligible for child's supplemental security income benefits under sections 1602 and 1614(a)(2)(A) of the Social Security Act.

It is the decision of the Appeals Council that, as of November 28, 1987, the claimant has been disabled under section 1614(a)(3)(A) of the Social Security Act.

The component of the Social Security Administration responsible for authorizing supplemental security income payments will advise the claimant regarding the nondisability requirements and, if eligible, the amount and the month(s) for which payment will be made.

APPEALS COUNCIL

Bernard A. Dowgiello, Member

Larry K. Banks, Member

Date: August 3, 1989

No. 88-1377

10

FILED
SEP 17 1989
JOSEPH F. SPANOL, JR.
CLERK

IN THE
Supreme Court of the United States
OCTOBER TERM, 1988

LOUIS SULLIVAN, Secretary of the United States
Department of Health and Human Services,
Petitioner,

v.

BRIAN ZEBLEY *et al.*,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Third Circuit

**BRIEF OF AMICI CURIAE
AMERICAN ACADEMY OF CHILD AND
ADOLESCENT PSYCHIATRY,
AMERICAN PSYCHIATRIC ASSOCIATION,
ASSOCIATION FOR RETARDED CITIZENS
OF THE UNITED STATES,
NATIONAL ALLIANCE FOR THE MENTALLY ILL,
NATIONAL ASSOCIATION FOR RIGHTS
PROTECTION AND ADVOCACY,
NATIONAL ASSOCIATION OF PRIVATE
RESIDENTIAL RESOURCES, AND
NATIONAL MENTAL HEALTH ASSOCIATION
IN SUPPORT OF RESPONDENTS**

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1988

No. 88-1377

LOUIS SULLIVAN, Secretary of the United States
Department of Health and Human Services,
Petitioner,

v.

BRIAN ZEBLEY *et al.*,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Third Circuit

**BRIEF OF AMICI CURIAE
AMERICAN ACADEMY OF CHILD AND
ADOLESCENT PSYCHIATRY,
AMERICAN PSYCHIATRIC ASSOCIATION,
ASSOCIATION FOR RETARDED CITIZENS
OF THE UNITED STATES,
NATIONAL ALLIANCE FOR THE MENTALLY ILL,
NATIONAL ASSOCIATION FOR RIGHTS
PROTECTION AND ADVOCACY,
NATIONAL ASSOCIATION OF PRIVATE
RESIDENTIAL RESOURCES, AND
NATIONAL MENTAL HEALTH ASSOCIATION
IN SUPPORT OF RESPONDENTS**

Amici curiae, organizations of mental health and mental retardation professionals, families and advocates with a special concern for children, address a single question in this brief: Whether the exclusive use of the Secretary's "listings"

of impairment to assess eligibility for Supplemental Security Income ("SSI") benefits for children with mental disabilities, without a separate assessment of residual functional capacity, violates the Social Security Act. Children with mental disabilities represent half of all SSI disabled children.¹ The methods of assessment of disability among these children illustrate the arbitrariness of the approach the Secretary uses for disability evaluation in all children.

The parties have consented to the filing of this brief. Letters of consent are attached.

INTEREST OF AMICI CURIAE

Amici are organizations that share a strong commitment to meeting the needs of children with mental disabilities, especially those who live in poor families. They all work to assure that programs established by Congress are faithfully carried out by those responsible for their administration.

The American Academy of Child and Adolescent Psychiatry is a national professional association of more than 4,100 child and adolescent psychiatrists. Its members are physicians who have completed a general psychiatry residency and two years' additional residency training in child and adolescent psychiatry. This medical discipline is concerned with the prevention, diagnosis and treatment of developmental and psychiatric disorders in children, adolescents and families.

The American Psychiatric Association, founded in 1844, is the nation's largest organization of physicians who specialize in psychiatry, with more than 35,000 members. The Association and its members have been actively involved in the process by which the Secretary of Health and Human Services determines whether mentally ill persons are entitled

¹ House Committee on Ways and Means, *Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*, 101st Cong., 1st Sess. 699-700 (1989).

to Social Security and SSI disability benefits. It has advised Congress and the Secretary concerning standards and procedures that should be used in benefits determinations and its individual members participate in the treatment and evaluation of disability applicants.

The Association for Retarded Citizens of the United States, with 160,000 members and 1,300 local chapters, is the largest voluntary organization devoted to securing the rights of and effective services for the approximately 6 million adults and children who are mentally retarded. It participates actively in formation of public policy concerning citizens with mental retardation and has been recognized in Congress, in state legislatures, in administrative proceedings and in the courts, as fairly and fully representing the interests of citizens with retardation and their families. It has worked with the Social Security Administration for decades on programs affecting people with mental retardation.

The National Alliance for the Mentally Ill represents 60,000 parents, spouses, siblings and children of mentally ill persons, as well as mentally ill clients themselves. It is organized into state alliances and more than 800 local affiliates. As a family movement, it provides self-help and supportive services, conducts a vigorous education campaign against the stigma of mental illness, and advocates for increased research on the causes and cures of mental illness and improved treatment and rehabilitative services for those afflicted with serious mental illness.

The National Association for Rights Protection and Advocacy (NARPA) is the only national organization that addresses both mental health and retardation issues and that includes in its membership a broad spectrum of state departmental administrators, specialists in treatment and habilitation, professional advocates, and former and present recipients of mental health and retardation services. NARPA has been invited to testify on several occasions before the United

States Congress concerning the legal rights of people with mental handicaps and has filed *amicus* briefs in this Court.

The National Association of Private Residential Resources represents about 600 agencies which together provide residential services for more than 35,000 children and adults with developmental disabilities. Its goal is to represent and assist providers of residential services in meeting the needs and improving the quality of life of people with mental retardation and other developmental disabilities. The people these agencies serve need public support to obtain services to help them become more independent.

The National Mental Health Association is a citizen advocacy organization concerned with all aspects of mental illness and mental health. Since its formation in 1909, the NMHA has worked to improve the care and treatment of persons with mental illness, promote mental health and prevent mental illness. The NMHA's 650 local chapters and state divisions and its more than one million volunteers and supporters work toward these goals through a wide range of activities in social action, education, advocacy and public information.

STATEMENT OF THE CASE

The number of children with mental disabilities continues to grow. Studies conducted by the Congress' Office of Technology Assessment estimate that mental impairment is present in 12% of the 63 million American children under the age of 18. Nearly half of these 7.5 million children are considered severely disordered or handicapped by their impairment.² Among inner-city children, who are often

² Office of Technology Assessment, *Children's Mental Health: Problems and Services - A background paper* (Publication No. OTA-HP-H-33) (1986).

exposed to severe social and financial deprivation, the rate of disability is even higher.³

Children burdened by poverty and disability are eligible to seek children's benefits under the Supplemental Security Income (SSI) program. SSI, created under Title XVI of the Social Security Act, 42 U.S.C. § 1382e *et seq.* (1982), provides subsistence income to needy disabled, blind and aged persons, including poor children under the age of 18 who have disabilities. The children's SSI disability program is designed to provide indigent families with the extra financial resources they inevitably need to raise children with disabilities: money for special diets, for transportation to clinics, physicians and rehabilitation facilities, for special services not covered by any medical assistance program, for skilled child care and for a range of individual needs too numerous to catalogue. Further, the extraordinary time demands required to meet the child's needs often limit the parents' ability to work, rendering the family dependent on financial assistance afforded by SSI. Finally, the child's eligibility for critically important medical care funded through Medicaid often hinges on receipt of SSI benefits.⁴ Yet only a small fraction of indigent children with mental disabilities receive SSI: 280,000 nationwide.⁵

³ National Institute of Medicine, *Research on Children and Adolescents with Mental, Behavioral and Developmental Disorders: Mobilizing a National Initiative* (1989).

⁴ A recent survey of four states found that while SSI disabled children accounted for between one and five percent of the Medicaid child population, they accounted for between 14 and 35 percent of Medicaid expenditures for children. Expenditures for inpatient hospital care are up to seven times greater for SSI disabled children than for children whose Medicaid eligibility derives from receipt of Aid to Families with Dependent Children. Rymer & Adler, *Children and Medicaid: The Experience in Four States* (1987).

⁵ United States Department of Health and Human Services, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement, 1988*, Table 9.B8. The number of children potentially eligible for SSI is not

The SSI Program for Children

In fashioning the disability program for children, Congress directed the Secretary of Health and Human Services to create eligibility standards that would cover disabling impairments in children if they were of "comparable severity" to a disabling impairment in an adult. The statute provides:

An individual shall be considered to be disabled for the purpose of this Title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity). . . .

42 U.S.C. § 1382c(a)(3)(A) (1982 & Supp. IV 1986) (emphasis added).

To implement that requirement, the Secretary has created eligibility rules, called "listings," consisting of a set of signs, symptoms and certain functional deficits which the Secretary considers disabling. *Bowen v. City of New York*, 476 U.S. 467, 470-71 (1986). Only if the child's condition "meets" these listings is he or she considered disabled.⁶ 20 C.F.R. § 416.924.

known. Fox and Greaney, using data from the National Health Interview Survey, estimate that only 10 percent of eligible children receive benefits, though they state that the estimate is derived from a relatively small sample. Fox & Greaney, *Disabled Children's Access to Supplemental Security Income and Medicaid Benefits* 9 (1988) (lodged with the Clerk).

⁶ The Secretary also theoretically allows benefits for individuals with conditions that do not meet the listings, but are determined to be medically equal to a listed impairment. The "equals" concept, however, is almost never used in mental impairment cases. *Jt. App.* 77-78. Further, heightened intensity in one symptom can never be used to justify an "equals"

The Secretary also uses listings to determine disability in adults, but the adult listings play a very different role in the determination process. The adult listings are an administrative shortcut, a device to decide claims favorably to claimants without full development of the evidence. *City of New York*, 476 U.S. at 471. If an adult with a severe mental or physical impairment does not have a condition that "meets" the listings, the Secretary engages in two kinds of further evidentiary development and evaluation.

First, he gathers evidence to consider in detail the person's "residual functional capacity." That is defined by the Secretary as "what you can do despite your limitations." 20 C.F.R. § 416.945(a). The assessment of residual functional capacity is an objective and highly individualized assessment of the person's actual ability to function, "including limitations that go beyond the symptoms of [the person's] medical condition." *Id.* For people with severe mental impairments who do not meet the listing, this assessment is "crucial." *Jt. App.* 181. Second, the Secretary investigates the person's vocational profile through an examination of age, education and prior work experience. 20 C.F.R. § 416.960.

For an adult claimant, therefore, failure to have a listed condition has no adverse consequences. Rather, it merely triggers the next steps in the evaluation process, notably the individualized evaluation of the person's ability to function appropriately in a variety of settings. If a child's condition does not meet the listings, however, his claim is denied.

The Disability Assessment Rules for Children with Mental Disabilities

The Secretary's reliance on listings alone for children's disability claims derived from a more general theory of disability assessment adopted by SSA in the late 1970s.

determination if all other criteria for the listing are not met. *Jt. App.* 81, 255.

According to that theory, functional limitations could be inferred or derived from medical data, such as signs, symptoms and laboratory findings, rather than by actual assessment of those limitations. Under this reasoning, the listings allowed evaluation of these medical criteria, so the separate residual functional capacity determination required in the regulations to ascertain actual ability to work was "redundant." *City of New York v. Heckler*, 578 F. Supp. 1109, 1116 (E.D.N.Y. 1984), *aff'd*, 742 F.2d 729 (2d Cir. 1985), *aff'd sub nom. Bowen v. City of New York*, 476 U.S. 467 (1986). As a consequence, even for adults, the Secretary relied exclusively on what the Secretary calls "medical" factors, by which he meant excluding the assessment of residual functional capacity.⁷ He therefore denied the claim of any person whose condition did not meet the level of severity specified in one of the mental impairment listings. *Id.*, 578 F. Supp. at 1115. In addition, the theory held that functional limitations were only relevant to the extent that *all* functioning was impaired.

When the childhood disability rules were promulgated in 1977, the Secretary applied the same medical and scientific assumptions. Thus, upon promulgating the children's listings, the Secretary stated: "We agree that for those impairments common to both adults and children the proposed Listing corresponds to the adult Listing, with modifications of the adult criteria, where necessary, to take into account the different impact on children." 42 Fed. Reg. 14706 (March 16, 1977). Instead of the "covert" exclusion of the residual functional capacity assessment from the evaluation process, however—the policy for adults, *City of New York*, 476 U.S. at 474—elimination of this assessment was explicitly set forth in the rules for children.

⁷ The Secretary's use of the term "medical" to exclude the assessment of residual functional capacity, e.g., Pet. Br. 38, is confusing and, in fact, contrary to the definition of residual functional capacity in the regulations. The regulations state flatly: "Residual functional capacity is a medical assessment." 20 C.F.R. § 416.945(b).

The four childhood mental impairment listings thus follow the adult listings then in effect: organic brain syndrome, psychotic disorders, non-psychotic disorders and mental retardation.⁸ Further, following the thinking applied to adult disability assessments, the listings either exclude evidence of functional limitations altogether or require that all areas of functioning be impaired.

Accordingly, the children's listing for chronic brain syndrome, 20 C.F.R. Part 404, Subpart P, Appendix I § 112.02, Jt. App. 232, is modeled on the old adult listing for chronic brain syndrome, and requires "arrest of developmental progression for at least six months or loss of previously acquired abilities." Notably, complete arrest in development is required; no consideration is given to specific delays in development, such as in language, gross and fine motor skills or social interaction, and degree of functional impairment. In other listings, for psychotic and non-psychotic psychiatric disorders in children, functional limitations are considered, but only to the extent that *all* aspects of functioning are impaired, including marked restriction in performance of daily age-appropriate activities, constriction of age-appropriate interests, deficiency of age-appropriate self-care skills and seriously impaired ability to relate to others. Jt. App. 232-233.

These rules are extremely restrictive. For example, the following children would not meet the listings:

- * a child who is seriously depressed, anxious or psychotic, but is able to dress himself and to eat unassisted or with minimal assistance.
- * a severely hyperactive child with a secondary behavioral communication disorder, but who retains some self-care skills.

⁸ On August 14, 1989, the Secretary proposed new rules for evaluating mental impairment in children. 54 Fed. Reg. 33238 (Aug. 14, 1989).

- * a child with an IQ between 60 and 69 who has severe behavioral, perceptual or communication problems, but who does not suffer a separate and independent impairment as well (neurological impairments such as severe perceptual problems, poor visual-motor coordination and severe communication problems are not considered separate because some experts consider them related to the retardation).
- * an infant or toddler who, though showing severe developmental delays, does not fail to achieve all developmental milestones.
- * a child with severe emotional and behavioral disorders who has self-care skills.

Highly dissatisfied with the medical and scientific bases of the old mental impairment disability evaluation criteria, Congress in 1984 ordered the Secretary to write new ones. Social Security Disability Benefits Reform Act of 1984, 42 U.S.C. § 421 note (Supp. IV 1986). Pursuant to this mandate, the Secretary issued new assessment rules for adults, 50 Fed. Reg. 35038 (Aug. 28, 1985), Jt. App. 179-199, including both listings and residual functional capacity guidelines, which significantly altered the criteria for evaluation of disability in adults. Recently, the Secretary issued proposed new listings for children with mental disabilities, 54 Fed. Reg. 33238 (Aug. 14, 1989), but these rules, if adopted, still do not require a separate residual functional capacity assessment.

SUMMARY OF ARGUMENT

The Secretary's approach to assessing mental disability in children violates the statutory requirement that the Secretary pay benefits to a child whose impairment is of "comparable severity" to that of an adult. While the Secretary has considerable latitude in writing regulations and standards, they must still be "reasonable and proper," 42 U.S.C. § 405(a) (1982), a phrase construed by this Court to mean neither

arbitrary nor capricious. *Bowen v. Yuckert*, 482 U.S. 137 (1987); *Heckler v. Campbell*, 461 U.S. 456, 466 (1983).

The Secretary's approach is contradictory. He acknowledges that severity of disability in children must be "measured according to functional limitations imposed" by an impairment, 54 Fed. Reg. 33241 (Aug. 14, 1989), *see also* Pet. Br. 38, but nevertheless excludes from consideration "the individual child's ability to function as such." Pet. Br. 42. Indeed, he goes so far as to deny children even the opportunity to show that their functioning is so impaired that they should be considered disabled. The process amounts to a perverse game of chance, depending not on the degree of disability, but on the presence or absence of certain signs or symptoms or functional limitations that the Secretary happens to include in the listings, from which he deduces disability.

This inconsistency is not a product of a dispute concerning the meaning of "comparable severity," but of the assessment methods necessary to carry it out. For 15 years, the Secretary has recognized—as recently as August, 1989, in proposed new listings for mental impairments, 54 Fed. Reg. 33241 (Aug. 14, 1989)—that disability in children, like disability in adults, must be defined in functional terms. Yet he insists that he can somehow figure out the degree of the child's functional limitations even as he excludes individualized evidence showing precisely what those limitations are.

The Secretary's refusal to perform a residual functional capacity assessment stems from a theory of disability assessment that has never been accepted by anyone in the field. It has been found arbitrary by the courts, *see Bowen v. City of New York*, 476 U.S. 467 (1986), and has been condemned by clinicians, researchers and the Congress. To be consistent with the statutory definition, the Secretary must engage in a residual functional capacity assessment for children. Indeed, for children with mental disabilities, individual functional assessment may be even more important than it is for adults.

That is because impairments have an enormously variable functional impact on individual children. As a result, the disability assessments used by professionals—but eschewed by the Secretary—rely far more heavily on evaluations of functioning than on signs, symptoms and laboratory findings.

The regulations, by excluding a residual functional capacity assessment for children, are therefore arbitrary and capricious.

ARGUMENT

THE SECRETARY HAS VIOLATED THE SOCIAL SECURITY ACT BY REFUSING TO ADHERE TO A FUNCTIONAL TEST OF DISABILITY.

This case is a reprise of *Bowen v. City of New York*, 476 U.S. 467 (1986). In each case the issue concerns the Secretary's decision to forego the assessment of a person's functioning that he recognizes as necessary to determine whether that person is disabled. In *City of New York*, the Secretary's error was to forego the functional assessment of mental disability in adults mandated in his own regulations and to substitute in its place a presumption that anyone whose condition was not serious enough to meet the criteria stated in the listing was not disabled. 476 U.S. at 473-75. Here, the mistake is to preclude, by regulation, the functional assessment that is essential under the Secretary's own definition of disability.

A. Functional Assessment Is the Central Ingredient in the Disability Determination.

The evaluation of a person's functional restrictions is the core of the evaluation of mental disability under the Social Security Act. See *Bowen v. Yuckert*, 482 U.S. 137 (1987); *Heckler v. Campbell*, 461 U.S. 456, 459-60 (1983). Rather than taking a strictly diagnostic approach, the disability program focuses on an assessment of the person's actual capacity to perform

relevant functional tasks. *Bowen v. City of New York*, 476 U.S. at 471. The Secretary's regulations recognize that "severity is assessed in terms of the functional limitations imposed by the impairment." Jt. App. 182. For adults, this assessment is contained not only in the listings, but in the fourth step of disability adjudication process, the "residual functional capacity" assessment, which "measures the claimant's capacity to engage in basic work activities." *Id.*⁹ This assessment, the Secretary has acknowledged, is "crucial." Jt. App. 181.

Functional criteria are equally critical for children. From the start of the SSI children's disability program, the Secretary accepted that childhood disability must be defined by reference to reduced levels of functioning. Accordingly, in the first instructions issued in 1973 about the SSI children's disability program, the Secretary acknowledged that "disability must be defined in terms of the primary activity in which they engage, namely growth and development, the process of maturation." Jt. App. 90. The following year, the Secretary issued more detailed guidelines on what he meant by "the process of maturation" and its relationship to childhood disability. He determined that he would focus on four discrete areas, all of which require an evaluation of the child's functioning. These were:

1. growth-increase in size and maturation of physical and functional characteristics;
2. learning;
3. mastering basic skills; and
4. emotional and social development.

Jt. App. 96. He added that the emphasis is on the "impact of the impairment on the child's life." Jt. App. 96.

⁹ The first three steps of the evaluation are designed to identify those who clearly are not entitled to benefits, those whose impairments are not severe or who are working, and those who are obviously disabled and entitled to benefits. *City of New York*, 476 U.S. at 471.

In 1977, when the children's disability listings were promulgated, the Secretary reiterated his commitment to a functional definition of disability. He stated that, when viewed as a whole, the standards for childhood disability must fairly and reasonably be calculated to identify impairments that "have a severe impact on a child's development in one form or another." 42 Fed. Reg. 14705 (March 16, 1977). The Secretary elaborated that the experts on whom he relied "placed primary emphasis on the effects of physical and mental impairments in children, the impact on the child's activities, and the restrictions on growth, learning and development imposed on the child by the impairments." *Id.* (emphasis added). This approach follows from the enormous variability in the impact a particular impairment has from one child to another.

The Secretary's own definition of comparable severity follows from this approach. It holds that the impairment must have an "impact on the child's development to the same extent that the adult criteria have on an adult's ability to engage in substantial gainful activity." *Id.*¹⁰ The Secretary has acknowledged that to be considered substantively "comparable" within the meaning of the statute, the standards applied to children with disabilities must be true to a functional and developmental understanding of disability. Preface to Children's Listings, 42 Fed. Reg. 14705 (March 16, 1977). Thus, according to the Secretary, the rules for children, like those for adults, must be premised on a medically and

¹⁰ Even the two lower court cases which the Secretary relies upon to support his position here, far from permitting the Secretary to exclude relevant functional and developmental criteria of disability, construed childhood disability in functional terms. In *Hinckley v. Secretary*, 742 F.2d 19 (1st Cir. 1984), the court explicitly referred to the Secretary's intent to examine the "effects" the impairment has on the child. *Id.* at 23. Similarly, in *Powell v. Schweiker*, 688 F.2d 1357 (11th Cir. 1982), the court referred to mental impairments as among those the Secretary agreed must "be evaluated in terms of the child's ability to function," 688 F.2d at 1360 and n.9.

scientifically respectable concept of the functional and developmental nature of childhood disability.

Indeed, the Secretary concedes now that "comparable severity" is defined in terms of an impairment's impact on a child—that is, how it affects his ability to function. Pet. Brief 37 (measure "impact" of impairment); 38 (measure "severity and impact"); 39 ("impact of the impairment on growth, learning and development"). The Secretary's most recent proposed rules for assessing mental impairment in children state flatly that "[i]n childhood cases, as with adults, severity is measured according to functional limitations imposed by a medically determinable impairment." 54 Fed. Reg. 33241 (Aug. 14, 1989) (emphasis added.)¹¹ These are enormous concessions, because the meaning of "comparable severity" is no longer at issue. Accordingly, contrary to the Secretary's position, deference to his interpretation of the statute in defining "comparable severity" is no longer at issue.

What is at issue is the Secretary's method of assessing functional loss, particularly his refusal to collect or, if he has collected it, to consider the very evidence necessary to assess functional loss in a particular case. At the same time that the Secretary recognizes that the essential measurement of disability is "impact" of an impairment on a child's functioning, he deliberately prevents the child from having the opportunity to show that impact through evidence of reduced functioning beyond the criteria in the listings.

Instead, as he candidly states, he relies exclusively on what he terms "medical factors alone," Pet. Br. 38, by which he means signs, symptoms, diagnoses and laboratory findings from which he infers functional loss. There is "no

¹¹ The contrast between the Secretary's position in the proposed new rules and his position before this Court could hardly be more striking. For example, his proposed rules state that "school records are a rich source of data," 54 Fed. Reg. 33243 (Aug. 14, 1989). His brief, however, says that "special education" is "not considered as such." Pet. Br. 40.

individualized consideration" of reduced functioning. Pet. Br. 36. He excludes competent psychiatric, psychological, social work, school and parental evidence "on the individual child's ability to function as such." Pet. Br. 42. There is therefore no place in the process even to receive evidence of the impact of the impairment on the child beyond what is contained in the listings. Unlike *Heckler v. Campbell*, 461 U.S. at 467, which upheld decisional rules that gave the claimant "ample opportunity" to present evidence relating to his own abilities, the rules here provide no opportunity at all for such a showing.

This approach is not only contradictory, but self-defeating. It is like trying to figure out what is wrong with a car by looking at its parts, but not listening to the owner describe what the car is doing wrong. The Secretary's job is not to be Sherlock Holmes, deducing from cryptic clues, but to design and carry out assessments that illuminate the degree of a child's functional limitations. The impact of impairments can only be determined by looking at an individual child's functional abilities.¹² The notion that listings alone can substitute for an individualized functional assessment has already been utterly repudiated by science, by courts and by Congress.

B. The Medical and Scientific Assumptions Underlying the Assessment Rules Are Baseless.

The contradiction between the functional definition of disability and the Secretary's virtually exclusive reliance on non-functional criteria for evaluation is a product of serious scientific and medical error as well as administrative irregularity. The methodology the Secretary uses is based on the erroneous assumption that functional deficits could be inferred from what the Secretary calls "medical evidence" alone—from signs, symptoms and laboratory findings. This

¹² Vocational factors, by contrast, are properly excluded from the assessment of disability in children, who have no work history.

assumption was, even at the time the listings were adopted, insupportable.¹³ It was finally abandoned by the Secretary when he promulgated new regulations for the evaluation of mental disability in adults in the face of judicial decisions, medical and scientific outcry and congressional pressure. Yet the repudiated approach remains embodied in the Secretary's approach to disability assessment in children.

1. Medical Criteria Alone Cannot Assess Functional Restrictions.

The theory that functional limitation can be inferred from signs, symptoms and laboratory findings, making a determination of residual functional capacity unnecessary, while zealously applied by SSA to both child and adult disability claims, never found support in medical and scientific research.¹⁴ When challenged, it was found arbitrary:

Scientific research and clinical data in the fields of psychiatry and rehabilitation psychology demonstrate that the Listing of mental impairments does not measure ability to work. Neither the symptoms contained in the A portion of the Listing, nor the daily functional ability provisions contained in the B portion of the Listing, measures or predicts ability to work.

¹³ See note 7, *supra*.

¹⁴ Goldman and Manderscheid, *The Epidemiology of Psychiatric Disability*, in *Psychiatric Disability: Clinical, Legal and Administrative Dimensions* 14 (Meyerson and Fine, eds. 1987). See also Hamilton, *Social Security Disability Programs: How They Work for the Mentally Impaired*, in *Psychiatric Disability*, *supra*, at 417 ("Study and research in the area have not established such a direct relationship" between signs and symptoms and disability); Anthony and Jansen, *Predicting the Vocational Capacity of the Chronically Mentally Ill: Research and Policy Implications*, 39 *Am. Psychologist* 537 (1984); Goldman and Gattozzi, *Balance of Powers: Social Security and the Mentally Disabled, 1980-1985*, 66 *Milbank Q.* 531 (1988); Rubenstein, *Science, Law and Psychiatric Disability*, 9 *Psychosocial Rehabilitation J.* 7 (1985).

Mental Health Association of Minnesota v. Schweiker, 554 F. Supp. 157, 162 (D. Minn. 1982), *aff'd*, 720 F.2d 965 (8th Cir. 1983). Similarly, in *City of New York v. Heckler*, 578 F. Supp. 1109 (E.D.N.Y. 1984), *aff'd*, 742 F.2d 729 (2d Cir. 1985), *aff'd* sub nom. *Bowen v. City of New York*, 476 U.S. 467 (1986), the district court found: "Medical experts demonstrated to the court that the symptoms and restrictions of the listings of impairments do not measure an individual's capacity for work or his or her ability to withstand the stress of even the least demanding work." 578 F. Supp. at 1124. As a result of SSA's reliance on this erroneous theory, though, "an individualized, realistic assessment of ability to work [was] not performed at any stage of the sequential evaluation process." *Mental Health Association of Minnesota*, 554 F. Supp. at 160-61.

This fundamentally flawed approach led to adjudicative chaos. The district court in *City of New York* aptly described the havoc that followed the substitution of the listings for the functional assessment mandated both by professional practice and by law:

SSA relied on bureaucratic instructions rather than individualized assessments and overruled the medical opinions of its own consulting physicians that many of those whose claims they were instructed to deny could not, in fact, work. Physicians were pressured to reach "conclusions" contrary to their professional beliefs where they felt, at the very least, that additional evidence needed to be gathered in the form of a realistic work assessment. The resulting supremacy of bureaucracy over professional medical judgments and the flaunting [sic] of published objective standards is contrary to the spirit and the letter of the Social Security Act.

Bowen v. City of New York, 476 U.S. at 474 n.5 (quoting district court findings). In *City of New York* alone, which covered only one state, in a three-year period more than 14,000

people were denied or terminated from benefits because of this rule.

The courts found that the medical criteria in the listings were an insufficient basis on which to render the assessment of a person's functioning that the Social Security Act required. They ordered that a realistic residual functional capacity assessment be made for each claimant who had a severe impairment.

After an extensive series of hearings and reports by the General Accounting Office, Congress addressed the same problem. It found "serious questions" about SSA's adjudication methods and noted that even "the Secretary has determined that a full scale re-evaluation of the Listings and current procedures is necessary." H.R. Rep. No. 619, 98th Cong., 2d Sess. at 15, 1984 U.S. Code Cong. & Admin. News 3052. Accordingly, § 5(a) of the Social Security Disability Reform Act of 1984, Pub. L. 98-460, 98 Stat. 1801, 42 U.S.C. § 421 note (Supp. IV 1986), mandated that the Secretary rewrite both the listings and the residual functional capacity guidelines. Congress underscored its criticism of the old approach by demanding that the new criteria "realistically" evaluate the claim of disability. 98 Stat. 1801.

The Secretary then completely overhauled his approach to adult mental impairment assessment. The Preface to the new rules utterly repudiates the Secretary's former approach to disability assessment. Rather than relying primarily, much less exclusively, on what the Secretary calls "medical" criteria, the Preface declares unequivocally that "severity is assessed in terms of the functional limitations imposed by the impairment." Jt. App. 182. Medical evidence is necessary only to establish the presence of a mental disorder. *Id.* The preface also warns that, because evidence of functioning is key, inferences drawn solely from medical evidence must be made with extreme care. For example, "mental status examination or psychological test data alone should not be used to accurately describe concentration and sustained ability to

adequately perform work-like tasks." Jt. App. 185. The new adult listings themselves, therefore, demand far greater attention to functional restrictions than did the old ones.

Equally important, the rules emphasize that, in view of the functional test of disability, no set of listings can capture the variety in the possible functional deficits an impairment can produce in an individual, nor can any set of listings provide an adequate opportunity for the individual to show the extent of functional loss. Jt. App. 181. Accordingly, despite the new and quite comprehensive functionally oriented listings,¹⁵ the rules stress the "crucial" importance of the residual functional capacity assessment for a person whose impairment does not meet the listings. Jt. App. 180.

This approach belies the Secretary's suggestion that, if his approach is flawed, the attack properly should be directed at a particular set of listings, not at the absence of an individualized functional assessment (Pet. Br. 42). Precisely because of the variation in the impact of any particular impairment on any person, child or adult, the search for total comprehensiveness—whether in the existing rules or the proposed new listings—is doomed. No set of listings can meet the statute's requirement.

The Secretary has joined medicine and science in rejecting, for adults, the premises on which the disability rules were originally constructed. But the Secretary's brief acknowledges that disability assessment in children remains based on "medical factors alone" (Pet. Br. 38) and that severity is measured "in medical rather than functional terms" (Pet. Br. 40). Putting aside the odd and contradictory way the Secretary employs the term "medical" in his brief (after all, residual functional capacity is a "medical" assessment

¹⁵ For example, the listings now take account of deficiencies in concentration and pace in a work-like setting and decompensation on the job. Jt. App. 179-99. Moreover, the categories of impairments have expanded from four to eight.

in the regulations¹⁶), the position cannot be squared with his own frequently articulated views or the mandates of the courts and the Congress. Yet the Secretary goes so far as to cite his 1977 statement that, contrary to his own new adult mental impairment regulations, his approach is "mandated" by the Social Security Act. *Id.* To reassert this rationale now in the face of the Reform Act and the new adult adjudication is virtually a confession of error.

2. *Functional Assessment Is as Critical for Children as for Adults.*

In determining the extent of a child's disability, there is no substitute for individualized functional assessment. Just as for adults, in assessing the overall impact of a developmental or behavioral impairment, mental health and mental retardation professionals attempt to assess the overall impact of the child's developmental, medical and behavioral problems on his day-to-day functioning in a variety of settings. The goal is not merely to provide a medical label for the child's problems, but to discover his needs and limitations. The critical assessment is to determine how his impairments limit his ability to function and ascertain the assistance necessary to meet the needs thus created. This is because a given diagnosis or medical evaluation, by itself, cannot necessarily specify any particular level of disability or course of treatment.

A number of factors render functional assessment even more important for children than it is for adults. Some problems, especially those in infants and young children, cannot be revealed by a single diagnosis or a psychometric instrument. For this reason, good disability assessments utilize a variety of means for evaluating specific skills and identifying disabilities and troublesome behaviors. Experts recommend a multi-disciplinary approach to the assessment

¹⁶ See note 7, *supra*.

of the functional significance of developmental disability as it is manifested in individual cases.¹⁷

Further, evaluation procedures performed in clinical settings often fail to ascertain the actual severity of the disability because they cannot assess the child over a long enough time or in the actual settings in which he is expected to perform daily. "Procedures that are quick, simple and economical have not been demonstrated to be highly reliable or valid."¹⁸ In other words, "Informal and standardized observations and questionnaires...are not very accurate for predicting behavior in the future or in other settings."¹⁹ Accurate assessments of functional capacity cannot be determined by a single visit to a physician absent input from other sources as to the child's performance in other settings.²⁰ A child who has self-care skills and does well at home may be completely unable to adjust to the demands of school, for example. For school-age children, the three

¹⁷ See, e.g., Chess & Thomas, *Origins and Evolution of Behavior Disorders from Infancy to Early Adult Life* (1984); Crocker & Cullinane, *The Function of Teams*, in *Developmental-Behavioral Pediatrics* 990 (M. Levine ed. 1983); Foster et al., *Screening for Developmental Disabilities*, 143 W.J. Med. 349 (Sept. 1985); Healy, *Screening for Disabilities*, 143 W.J. Med. 379 (Sept. 1985); Magrab & Lehr, *Assessment Techniques in Pediatric Psychology*, in *Handbook for the Practice of Pediatric Psychology* (J. Tuma ed. 1982).

¹⁸ Frankenburg, *Infant and Preschool Developmental Screening*, in *Developmental-Behavioral Pediatrics* 927, 930 (M. Levine et al. eds. 1983). Cf. Foster et al., *supra* note 17, at 355.

¹⁹ Liptak & Chamberlin, *Clinical Assessment of Behavioral Performance or Adjustment*, in *Developmental-Behavioral Pediatrics* 916, 921 (M. Levine et al. eds. 1983).

²⁰ The behaviors and capacities a child displays in the physician's office may be quite different from those he displays at home or at school. "No single set of observations — be it a neurodevelopmental examination, an intelligence test, or parent or teacher reports — should be taken as the ultimate word. Instead, it is the compilation and integration of data from multiple sources that is likely to provide the most accurate assessment of development." Levine, *The Developmental Assessment of the School Age Child*, in *Developmental-Behavioral Pediatrics* 938, 939 (M. Levine et al. eds. 1983).

main areas that should be examined are academic performance, peer relationships in and out of school, and social functioning at home and at school. Other aspects of the child's functioning may also be relevant to specific disorders.²¹ None of these can be gleaned from medical criteria alone (as the Secretary now uses that term), yet they are specifically excluded by the Secretary.

In addition, psychiatrists and developmental specialists may consider a child severely disabled for reasons other than their diagnosis. Some children may be significantly impaired in only one area of functioning, but unable to lead a normal life when compared to average children or to their own "baseline" (functioning prior to becoming ill or disabled). Other children may experience moderate to severe impairment in several areas of functioning, yet be much more like the average. The important point is that both kinds of children may be severely impaired.

Several disorders of low severity, moreover—none of which would, alone, completely disable a child—may be highly disabling when they occur together in a single child. Moreover, developmental experts agree that "children with multiple developmental or functional problems have been shown...to have more persistent difficulties than those with one problem."²²

The total effect of several moderate or severe handicaps may be a more severe overall impairment in daily performance than one would expect, given the particular disabilities

²¹ Puig-Antich & Rabinovich, *Major Child and Adolescent Psychiatric Disorders*, in *Developmental-Behavioral Pediatrics* 865, 866 (M. Levine et al. eds. 1983).

²² Palfrey et al., *The Identification of Children's Special Needs: A Study in Five Metropolitan Communities*, 111 J. Pediatrics 651, 656 (Nov. 1987).

viewed in isolation.²³ Often, such an additive disabling effect is best observed by challenging the child in settings in which he is expected to perform day-to-day (e.g., at home or at school), rather than confining the assessment to a clinical test designed to examine a particular skill or capacity.

Finally, the wide range of impairments considered typical of some developmental disorders makes it very difficult to assess children affected with those disorders based on medical criteria alone. For example, though autism²⁴ is considered a clinically recognizable problem, "the definitions for autism do not specify a specific disease or condition but rather a syndrome characterized by a large number of symptoms." A child need not present all of the symptoms in order to be diagnosed autistic, and children with very different symptomatology are often diagnosed autistic.²⁵

Some children labeled "autistic" display only a few of the behavior patterns characteristic of autism. Some possess

²³ Two experts note that "The specific or actual additive constraint to human development caused by the presence of more than one disability is obvious." Nelson & Crocker, *The Child with Multiple Handicaps*, in *Developmental-Behavioral Pediatrics* 828, 829 (M. Levine et al. eds. 1983).

²⁴ Childhood autism is "a developmental disability characterized by an onset before five years of age; a disturbance in the rate of appearance of physical, social, and communication skills; an abnormal response to sensation; absence or delayed development of speech or language; and abnormal ways of relating to people, objects, and events." Autistic children often do poorly on tests of intelligence, but autism is distinguished from mental retardation insofar as many autistic children have special "islands" of competence, and do better on a wider variety of intelligence tests than do children who are mentally retarded. Autism is distinguished from childhood schizophrenia, as well, mainly because autism has an earlier age of onset. "Autistic children require...treatment if they are to make adequate gains in communication, social, self-help, and academic skills." Christian, *Childhood Autism*, in *Developmental-Behavioral Pediatrics* 816, 827 (M. Levine et al. eds. 1983).

²⁵ Moreover, most treatment methods are symptom specific, since there are a wide variety of symptoms characteristic of autism and it is unlikely that a child will have all of them. Christian, *supra* note 24, at 816.

special abilities (like the "autistic savants" who have a particular area of competence or genius, despite overall disability). Others have severe deficits and no special skills.²⁶ Clearly, because some children with autism do have areas of special competence, an autistic child might well not meet the criteria under either the current or proposed listing.²⁷ Yet despite the variety of manifestations taken by childhood autism, it is considered by professionals to be a severely disabling illness, which warrants intervention according to the specific deficits displayed by the individual child.²⁸

For these reasons, clinicians recognize that it is essential to assess individual behavior patterns rather than to focus attention on diagnosing the child or to argue about the precise definitions of developmental disabilities such as autism.²⁹ In fact, "[d]escription rather than diagnosis is the desired goal in most cases."³⁰ And because an initial diagnosis does not necessarily specify in great detail "the behavioral excesses and deficits of the individual child,"³¹ individualized assessments must be made of the severity of the child's

²⁶ *Id.* at 822.

²⁷ One of the hallmarks of autism is withdrawal from social relationships and a lack of interest in events or people outside the self. Autistic children often relate to other people much as they would to mere objects. It is not unlikely, therefore, that an autistic child might experience marked restriction in performance of daily age-appropriate activities, constriction of age-appropriate interests, and impaired ability to relate to others, even though he might be able to care for himself in an age-appropriate manner.

²⁸ Christian, *supra* note 24, at 820, 821, 827. See also Introduction to *Major Handicapping Conditions*, *id.* at 756.

²⁹ See Christian, *Reaching Autistic Children: Strategies for Parents and Helping Professionals*, in *Coping with Crisis and Handicap* (A. Milunsky ed. 1981); and R. Koegel and L. Schreibman, *How to Teach Autistic and Other Severely Handicapped Children* (1981).

³⁰ Blackman & Levine, *A Follow-up Study of Preschool Children Evaluated for Developmental and Behavioral Problems*, 26 *Clinical Pediatrics* 249 (May 1987).

³¹ Christian, *supra* note 24, at 820.

illness, based upon examination of the child's capacities in a variety of settings. Attempts should be made to ascertain the particular strengths and weaknesses of the individual child "and their relevance to his performance in life."³²

We do not doubt the authority of the Secretary to vary his procedures for assessment of claims tailored to the characteristics and disabling effects of particular impairments. But he must use that authority in a manner that still respects a common underlying standard of disability and employs a methodology designed to elicit facts about the child relevant to that standard.³³ For children, the only method that respects the functional definition of disability requires an individualized assessment of functioning.

The Secretary's proposed new listings for children's mental impairments take a step in that direction by including more functional criteria. But the proposed listings are not—nor can they be—comprehensive. For example, they take no account of relatively common functional deficits such as inability to attend, impulsivity or hyperactivity. Given the impossibility of creating listings that take into account *all* relevant functional deficits, therefore, it is arbitrary to exclude an individual functional determination.

³² Levine, *supra* note 20, at 947.

³³ In some cases, of course, procedural differences in the evaluation process do reflect different substantive eligibility standards. The truncated evaluation process available to widows and widowers, for example, which omits an assessment of residual functional capacity or consideration of vocational factors, is the result of a different underlying standard of disability. 42 U.S.C. § 423(d)(2)(B) (1982) requires a widow or widower to show inability to perform "any gainful activity," rather than, in the case of wage earners themselves, "any substantial gainful activity."

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

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No. 88-1377

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OF RESPONDENTS BRIAN ZEBLEY, ET AL.**

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INTEREST OF AMICI

The United Handicapped Federation (UHF) is a non-profit corporation founded in 1974. UHF is headquartered in Minnesota and has approximately 15,000 members in a number of states; it represents a disability rights coalition of 51 organizations. The general membership of UHF is composed of persons

with disabilities, their parents, friends and relatives, concerned professionals and other interested persons. UHF pursues four goals on behalf of persons with disabilities: 1) to ensure their access to decision-making processes affecting their lives and concerns; 2) to promote their rights and responsibilities; 3) to assist their efforts to live independently and to participate fully in the community; and 4) to educate temporarily-abled people about the needs, concerns and image of persons with disabilities. A substantial portion of the UHF membership is indigent and receives public assistance, including Supplemental Security Income (SSI) and Medicaid. The UHF Medical Issues Task Force has participated as amicus curiae in several court cases involving threats to the provision of treatment and care for persons with disabilities. These cases have included children needing medical treatment. UHF and its Medical Issues Task Force are concerned about the impact the Secretary's child disability policies will have on the quality and availability of medical care for children with disabilities.

The Ethics and Advocacy Task Force of the Nursing Home Action Group advocates needed medical care and treatment for residents of nursing homes and long-term care facilities. Such persons, adults and children alike, are vulnerable to discrimination based on disability, illness, age or unjust economic priorities. The Task Force is a committee of the Nursing Home Action Group, a non-profit corporation with membership throughout the United States. Founded in 1983, the Nursing Home Action Group promotes the rights and interests of nursing home and long-term care facility residents, including a reported total of 100,000 children nationally, through legislation, advocacy, counseling, and networking. The majority of its membership consists of indigent persons with permanent physical or mental disabilities.

The UHF Medical Issues Task Force and the Ethics and Advocacy Task Force of the Nursing Home Action Group are represented by attorneys of the National Legal Center for the Medically Dependent and Disabled, a national support center

of the Legal Services Corporation. The National Legal Center for the Medically Dependent and Disabled serves indigent persons whose lives are jeopardized by denial of medical treatment or care on account of disability.

All parties have consented in writing to the filing of this brief.

SUMMARY OF ARGUMENT

The standards employed by the Social Security Administration to determine eligibility for Supplemental Security Income (SSI) and defended by the Secretary of Health and Human Services (hereinafter "the Secretary") treats children differently than adults. This different treatment raises equal protection and due process concerns; it also affects a large population of similarly vulnerable children by increasing the risk of discriminatory denial of medical services.

ARGUMENT

I. To Avoid Constitutional Concerns, The SSI Regulatory Scheme For Children Should Be Held Inconsistent With Congressional Intent.

Congress established the SSI program in 1972 to provide federal assistance to needy disabled, blind, and aged persons under Title XVI of the Social Security Act. 42 U.S.C. 1381-1383c (Supp. 1989). Pursuant to congressional direction, the Secretary has promulgated regulations to administer the SSI program. See 20 C.F.R. §§416.101 — 416.2119, Subpts. A-U (1987). At issue in this case are the regulatory standards (hereinafter "the Regulations" or "the regulatory scheme") that the Secretary created to determine SSI eligibility by measuring an applicant's level of mental or physical impairment. See 20 C.F.R. 416.920 (1987) and 20 C.F.R. 416.924 (1987).

Your amici agree with Respondents Brian Zebley, Joseph Love, Jr. and Evelyn Raushi that "the Secretary has estab-

lished two markedly different regulatory tests to measure the disabling severity of the impairments of adult and child claimants. This very disparate treatment is at the heart of this case."¹ Respondents' Brief in Opposition to Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit at 5.

The issue debated by the Secretary and the Respondents is not whether the Regulations treat children differently than adults. Quite clearly they do, and the Secretary admits this, though grudgingly. Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit at 4 ("Children are evaluated on a slightly different standard.") Rather, the parties dispute whether the Regulations, in treating children differently than adults, are consistent with the mandate of Congress. Do the Regulations properly implement the intent of Congress as expressed in 42 U.S.C. 1382c(a)(3)(A) (Supp. 1989)? What did Congress intend when it directed the Secretary not only to assist adults with severe impairments, but also to help children with impairments of "comparable severity?" The Secretary asserts one meaning of the crucial words "comparable severity" and the Respondents another.

When a statute may be interpreted in two or more ways, that interpretation "clearly in accordance with the provisions of the constitution is to be preferred." *Knight Templars' & Masons' Life Indemnity Co. v. Jarman*, 187 U.S. 197, 205 (1902). This

¹ The Regulations cut in two directions. They differentiate between adults and children, a "vertical" distinction. They also differentiate between medically impaired children with conditions meeting the Listing of Impairments and those other medically impaired children whose conditions do not meet the Listings, a "horizontal" distinction. Your amici will focus in this section on the constitutional implications of a "vertical" distinction between adults and children. The "horizontal" impact is also problematic, however. By extending SSI eligibility *only* to those children impaired to such a severe level as to be *presumed* disabled, the Secretary withholds eligibility from those children having no one condition as severe as a listed one, but who might *actually* be disabled when the combined impact of all the child's functional deficits is considered. There is no rational basis for the Secretary to choose to help presumably disabled children but not help those actually disabled.

long recognized rule "plainly must mean that where a statute is susceptible of two constructions, by one of which grave and doubtful constitutional questions arise and by the other of which such questions are avoided, [the Court's] duty is to adopt the latter." *United States ex rel. Attorney Gen. v. Del. & Hudson Co.*, 213 U.S. 366, 408 (1909). "This cardinal principle . . . has for so long been applied by this Court that it is beyond debate." *Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Construction Trades Council*, 108 S. Ct. 1392, 1397 (1988).

Your amici assert the SSI regulatory scheme, based on the Secretary's interpretation of the SSI statute, raises "grave and doubtful constitutional questions." If the Regulations are deemed consistent with the federal law authorizing the SSI program, then that law's constitutional validity is also suspect.

What are the Regulations' constitutional problems? The Regulations violate the rights of children with disabilities to equal treatment and due process of law.

A. The SSI Regulations Fail To Provide Equal Protection.

Your amici assert that the SSI Regulations fail to provide equal protection because they disfavor children, conflict with an important purpose of the SSI program and are unsupported by any rational basis.

1. The SSI Regulations discriminate against children with disabilities.

At one stage of the SSI eligibility process, both adults and children must attempt to prove that their physical or mental impairment matches an impairment defined and listed by the Secretary in a listing of impairments (hereinafter "the Listings") published in the Regulations. See 20 C.F.R. Pt. 404 Subpt. P, Apps. 1-2 (1987). The crucial and constitutionally defective difference between the Regulations' treatment of adults and their treatment of children occurs when a member of

either group fails to demonstrate that his or her impairments meet or equal any one impairment included in the Listings.

The SSI regulatory scheme at this stage disfavors children by denying them the opportunity to go beyond the Listings to seek individualized assessments of their "residual functional capacity" (RFC). Social Security Administration, Program Operation Manual System, Disability Insurance, §24505.015. As a result, unlike adults, children cannot demonstrate that the impairments they possess, considered separately or together, effectively disable them from doing "any substantial gainful activity." 20 C.F.R. §416.924 (1987). Instead, children must depend solely on "meeting or equaling" the higher severity threshold found in the Listings. The Listings contain only those medical impairments presumed by the Secretary to be so severe as to prevent individuals from performing "any gainful activity." 20 C.F.R. §416.925(a) (1987); 20 C.F.R. §416.925 (1987).

Adults, on the other hand, may present to the Secretary evidence of any functional limitations caused by medical impairments. 20 C.F.R. §§416.960 — 969 (1987). Separately, each impairment might fail to "meet or equal" the high severity level of those found in the Listings. Together, the combined impairments may be found to prevent the adult from performing any substantial activity, a lower severity level. Thus, the opportunity to show the combined effect of several impairments on one's functional capacities is afforded only to adults under the Regulations.

If adults cannot meet the higher severity threshold found in the Listings, then they still may meet the lower threshold found at the RFC assessment stage. An individualized RFC determination permits adults to go beyond the Listings to prove they are disabled and therefore SSI-eligible. In effect, therefore, adults carry a lighter burden when applying for SSI benefits.

These divergent regulatory schemes thus place before children obstacles to receiving SSI benefits greater than those encountered by adults. A disproportionately larger number of denials of SSI for children has thus resulted. See Appellants Reply Brief, Appeal from the United States District Court for the Eastern District of Pennsylvania at 2-3 ("The data further suggests that in contrast to the adult program many more severely disabled children apply, get beyond the "severe" mental or physical impairment stage [of evaluation], but get turned down *not* because of other reasons such as excess income or resources, short duration of impairment, or insufficient medical evidence, but largely because they do not 'meet or equal' the Listings standards.")

As your amici will show, this different treatment is wholly unrelated to, indeed contravenes, an important purpose of the SSI program. Hence, under equal protection analysis, the different treatment is "so attenuated" to the SSI program's goals as to be arbitrary and irrational.

2. By discriminating against children with disabilities the SSI Regulations conflict with an essential purpose of the SSI program: providing access to healthcare financing under Medicaid for both adults and children.

The constitutional guarantee of equal protection "is essentially a direction that all persons similarly situated should be treated alike." *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 439 (1985). Government action is invalid under equal protection analysis if it interferes with a fundamental right or discriminates against a suspect class. *Kadrmas v. Dickinson Public School*, 108 S. Ct. 2481, 2487 (1988). Cases involving governmental distinctions based on age, *Massachusetts Board of Retirement v. Murgia*, 427 U.S. 307, 313 (1976), or mental disability, *Cleburne*, 473 U.S. at 442, according to this Court, do not involve suspect or a quasi-suspect

classifications. In such cases, a rational basis test is applied: the classification drawn must rationally relate to a legitimate government interest. *Lyng v. International Union*, 108 S. Ct. 1184, 1191-92 (1988).

This test, though deferential, "is not a toothless one." *Mathews v. Lucas*, 427 U.S. 495, 510 (1976). "Arbitrary and irrational discrimination violates [equal protection guarantees in the Constitution] under even our most deferential standard of review." *Bankers Life & Casualty Co. v. Crenshaw*, 108 S. Ct. 1645, 1653 (1988). Thus, for example, the Secretary "may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *Cleburne*, 473 U.S. at 446.

As acknowledged by the Secretary, Congress not only intended to provide income supplements under SSI, but also intended to broaden access to health care. See Brief for the Petitioner at 45. States are encouraged by Congress to automatically qualify SSI recipients for state Medicaid health coverage. 42 U.S.C. §1396a (a)(10)(A)(i) (Supp. 1989). (Forty-one states now extend automatic coverage under Medicaid to all disabled children and adults receiving SSI. Fox & Greaney, Disabled Children's Access to Supplemental Security Income and Medicaid Benefits 27 (Dec. 1988)). An intended result of the SSI program is to place desperately needed health care financing within the reach of adults and children with disabilities.

The SSI program is *not* intended *only* to assist those persons whose disabilities prevent them from earning a living. This employment-oriented purpose co-exists with another: the purpose of providing access to health care. The latter purpose relates to adults and children equally. Both adults and children can benefit from and achieve rehabilitation through health services.

Thus, children and adults should be treated equally under SSI to further Congress' intent to avail health care to all persons with disabilities. The Secretary should not distinguish

between adults and children on the basis of their functional capacities in determining whether or not to provide SSI. SSI eligibility decisions ultimately affect many applicants' chances of receiving Medicaid coverage, which in turn governs their ability to obtain needed health care. Denying RFC assessments from children while providing the same to adults treats similarly situated classes differently on the basis of an irrelevant distinction. This different treatment contravenes the Fifth Amendment's guarantee of equal protection.

3. The SSI Regulations are unsupported by any rational basis.

The Regulations will not survive even minimal equal protection scrutiny unless the Secretary included in the administrative record a rational basis for treating children differently than adults. Regulations can only be upheld, "if at all, on the basis articulated by the agency itself." *Motor Vehicle Mfrs. Assn. v. State Farm Mut.*, 463 U.S. 29, 50 (1983). If no justification is provided at the time a federal regulation is promulgated, then this Court refuses to search for any "conceivable basis" to save the regulations from constitutional invalidation. "Agency deference has not come so far that we will uphold regulations whenever it is possible to 'conceive a basis' for administrative action. To the contrary, the 'presumption of regularity afforded an agency in fulfilling its statutory mandate,' is not equivalent to 'the minimum rationality a statute must bear in order to withstand analysis under the [Fifth Amendment's] Due Process Clause.'" *Bowen v. American Hospital Assn.*, 476 U.S. 610, 626 (1986) 'citing *State Farm Mut.*, 463 U.S., at 43 n.9). Any such regulation would therefore be unconstitutional because the agency failed to carry out its duty to explain the rationale and factual basis of its action. *Id.*

The administrative record created when the SSI Regulations were promulgated offers no clue why the Secretary believes *functional* evaluations, as opposed to *vocational* ones, are inappropriate for children. As noted by one federal district court that disapproved the child SSI regulatory scheme:

The Secretary does not attempt to grapple with the application of inconsistent statutory standards, nor does he address the inherent flaws in the cookbook adjudicatory format of his regulatory scheme. Instead, he repeatedly announces that the determination of a child's RFC would be inappropriate since the statute does not require application of the vocational factors to child SSI claims. This is a *non sequiter*. Determination of the child's functional capacities in light of his or her medical condition — a medical determination — operates separately from step five in the regulatory scheme, which applies a wage earner's vocational factors.

Marcus v. Bowen, 696 F. Supp. 364, 381 (N.D. Ill. 1988).

An after-the-fact justification will not save the Regulations if the justification finds no support in the administrative record. The mere fact there might be "some rational basis within the knowledge and experience of the regulators, under which they might have concluded that the regulation was necessary to discharge their statutorily-charged mission, will not suffice to validate agency decision-making." *Bowen v. American Hospital Assn.*, 476 U.S. at 627. Even if the Secretary's last minute efforts to explain his actions (*see* Petitioner's Brief, at 41-46) provided this Court with a reasonable basis for the SSI policy (which your amici do not concede), the absence in the administrative record of any justification and corresponding evidentiary support is nonetheless constitutionally fatal.

Assuming for the sake of argument the Secretary had met his burden of articulating in the administrative record some basis for discriminating against disabled children, that basis itself is still susceptible to constitutional challenge. If the "facts on which the classification is apparently based could not reasonably be conceived to be true by the decisionmaker," then the classification will not survive equal protection scrutiny. *New York State Club Assn., Inc. v. City of New York*, 108 S. Ct. 2225, 2236 (1988) (quoting *Vance v. Bradley*, 440 U.S. 93, 111 (1979)). That is, a constitutional challenge will succeed if evidence is submitted "to show that the asserted grounds for the

... classification lack any reasonable support in fact." *City of New York*, 108 S. Ct. at 2236.

The Secretary has offered this Court several assertions he claims justify the SSI Regulations' different treatment of children and adults. Your amici argue that these assertions are "erroneous and that the issue is not truly debatable," *see* 108 S. Ct. at 2236, and that the Regulations therefore lack any rational basis.

The Secretary argues that children are not provided individualized assessments beyond the Listings because such assessments are concerned with work-related capacities. Because children generally do not have past work experience or seek employment, the Secretary argues it is rational to provide RFC evaluations for adults, but not for children.

Your amici disagree. According to the Regulations themselves, the individual assessments provided to adults consist of two different evaluations: functional and vocational. The functional RFC evaluation is defined as a "medical assessment" based on criteria not solely work-related. 20 C.F.R. §416.925 (1987). RFC determinations measure such physical abilities as "walking, standing, lifting, carrying, pushing, pulling, reaching, [and] handling" (20 C.F.R. §§404, 1545(b), 416.945(b) (1987)), and such mental "factors . . . as [the] ability to understand [and] to carry out and remember instructions" (20 C.F.R. §§404.545(c), 416.945(c) (1987)).

The vocational assessments of age, education, and work experience are clearly distinguished in the Regulations from RFC determinations. *See* S. S. R. 83-10 (West Soc. Sec. Rep. Serv. Supp. 1988); *Marcus v. Bowen*, 696 F. Supp. at 381 ("Determination of the child's functional capacities in light of his or her medical condition — a medical determination — operates separately from step five in the regulatory scheme, which applies a wage earner's vocational factors".)

On the one hand, children are different from adults with respect to their present connection to the work force and their

present employability. On the other hand, children as well as adults can be functionally impaired and thus functionally evaluated according to age-appropriate standards. For adults, functional impairments may hinder or extinguish their ability to hold a job, an age-appropriate activity. For children, functional impairments may interfere with such age-appropriate tasks as school, social interaction, physical mobility, or other activities related to social and educational development. The impact on adult or child age-appropriate abilities is equally measurable through an RFC assessment. Thus, there is nothing so inherently "job-related" about an RFC assessment that should limit its applicability only to adults.

Because it is a functional and not solely job-related assessment, the RFC evaluation is equally applicable to children and adults. Therefore, children should not be denied the opportunity to receive individualized, medically determinable, *functional* evaluations.

The Secretary also asserts that employing functional assessments for children across the board would be unworkable. Brief for the Petitioner at 44. This assertion is unreasonable since the Secretary already provides children certain, though severely limited, opportunities within the Listings for individualized assessments patterned after those afforded adults. Thus, RFC-evaluations for children are not technologically or administratively impossible. In addition, the Secretary requires individualized functional and even vocational assessments of children in cases where children on SSI have to be reassessed when medical improvement may have occurred. (See 20 C.F.R. §416.994(c) (1987): An inquiry is needed into "whether this medical improvement is related to your ability to work (i.e., your ability to perform age-related activities.)")

The Secretary also asserts that the Listings for children are a sufficient substitute for across-the-board functional assessments. Brief for the Petitioner at 42. This also is an unreasonable assertion given the Secretary's own recognition of the Listings' incomplete scope.

Responding to a public comment submitted in 1978 that the Listings failed to include numerous disabling conditions, the Secretary concurred: "This is true. The Listing criteria are intended to identify the more commonly occurring impairments shown in applications for social security disability benefits." 44 Fed. Reg. 18175 (1979). Another comment argued that the Listings insufficiently described the symptoms of multiple sclerosis. *Id.* at 18176. The Secretary replied:

It is not possible . . . to reduce these multiple manifestations to a listing. The Listing is but one item in the evaluation process. We evaluate cases of claimants whose conditions do not meet or medically equal the criteria of a listed impairment under other rules. Under these rules we consider the person's condition, age, education, and work experience to determine whether the person is disabled.

Id.

The Third Circuit Court of Appeals echoed the Secretary on the Listings' incompleteness by noting "numerous examples alleged by amici . . . demonstrate the inadequacy of the Secretary's exclusive reliance [in children's cases] on the medical listings." *Zebley v. Bower*, 855 F.2d 67, 72 (3rd Cir. 1988). The Third Circuit thus ruled that children should be provided individualized assessments because,

[t]he listings . . . do not purport to be an exhaustive compilation of medical conditions which could impair functioning to the extent necessary to satisfy the statutory standard for liability. The regulations recognize this by providing for individualized assessment of the *actual* degree of functional impairment of adults whose medical findings do not entitle them to a *presumption* of disability by meeting or equaling the listing.

Zebley, at 73 (emphasis in original).

Finally, the Secretary argues that requiring individualized assessments for children would be time-consuming (Brief for

the Petitioner, at 44 n. 25) and expensive (Petition for Writ of Certiorari, at 18). These claims do not save the regulatory scheme from constitutional infirmity. Though "fiscal integrity . . . is a legitimate concern of the State," *Lyng*, 108 S. Ct. at 1193, "[t]his does not mean that [government] can pursue the objective of saving money by discriminating against individuals or groups." *Id.*

In sum, the Secretary fails to demonstrate that the Regulations are rational or non-arbitrary. The scheme is, rather, inconsistent with and so attenuated to the purposes of the SSI program that the Regulations fail to provide equal protection.

B. The SSI Regulations Fail To Provide Due Process.

The Regulations preclude children from going beyond the Listings to obtain individualized assessments of their functional limitations. In doing so, the Regulations deny children an essential opportunity afforded adults through an RFC assessment to support their claims to SSI benefits by submitting all relevant information about their condition.

For adults, an RFC assessment is deemed by the Secretary to be "crucial if the person does not meet or equal the Listings." 50 Fed. Reg. 35042 (1985) (emphasis added). The scheme for adults thus furthers the statutory mandate to consider the "combined effect of all the individual's impairments," 42 U.S.C. §1382c(a)(3)(G) (Supp. 1989), and "all [the] evidence available" about the individual's disability. 42 U.S.C. §1382c(a)(3)(H) (Supp. 1989).

Disability benefits are "property" under the Fifth Amendment, *Mathews v. Eldridge*, 424 U.S. 319, 332 (1976), and due process protections should be available to persons already receiving public benefits as well as to those simply applying for eligibility. *Walters v. National Association of Radiation Survivors*, 473 U.S. 305, 320 n.8 (1984); see also *Wright v. Califano*, 537 F.2d 345, 354 (7th Cir. 1978) ("denials do not necessarily deserve less due process protection than terminations").

The due process guarantee of the Fifth Amendment forbids the government from depriving property from persons without affording those persons an opportunity to be heard "in a meaningful manner." *Mathews v. Eldridge*, 424 U.S. at 333. To be meaningful, "the hearing required by the Due Process Clause must be . . . 'appropriate to the nature of the case.' It is a proposition which hardly needs explication that a hearing which excludes consideration of an element essential to the decision . . . does not meet the standard." *Bell v. Burson*, 402 U.S. 535, 541-42 (1971). But the Regulations exclude from consideration of children for SSI eligibility any evidence of disability not specified in the Listings, irrespective of a child's actual level of functional impairment. Because the Listings are incomplete, this categorical exclusion of evidence probative of functional disability denies children a meaningful opportunity to be heard. The Regulations therefore deny due process to children.

In sum, both the Regulations and the SSI statute are constitutionally defective if the Regulations are found to be consistent with congressional intent. This Court can avoid these constitutional problems by finding the Regulations conflict with the mandate of Congress.

II. The SSI Regulatory Scheme Impacts on a Large Population of Similarly Vulnerable Children.

The United State Department of Health and Human Services (HHS) reported in 1986 that six percent of all live births (216,000 children) are admitted each year to neonatal intensive care units in the United States, and that 2.5 percent (90,000 children) annually are born with major disabilities, such as cleft lip, heart murmur, and "truly life-threatening conditions." *Financial Support for Disabled Infants with Life Threatening Conditions: A Report to Congress*, Executive Summary, Health and Human Services (Mar. 28, 1986).

Approximately 30 percent of all persons under age 18 are affected by chronic physical or mental impairments. New-

acheck, *The Costs of Caring for Chronically Ill Children*, 4 Business & Health 18 (1987). Almost 1 million children are limited in their ability to participate in minor activities, such as sports and recreational pursuits. *Id.* at 19. Another 1 million children are more severely limited by chronic illness and are restricted in the kind or amount of their major activities such as school for school-age children and play for preschool-age children. *Id.* At the most severe end of the spectrum are children unable to engage in *any* major childhood activities. Nationwide, approximately 150,000 children, including about 100,000 residing in long-term care institutions, fall into this category. *Id.*

Thus, many infants and children today have physical and mental disabilities, often serious enough to be life-threatening. These children require continued medical, social, and emotional assistance as they grow and mature. This assistance not only would sustain life, but could — increasingly with medical advances — provide the means to rehabilitate these children to become productive adults.

The SSI regulatory scheme's impact on children with disabilities is better understood by example. Consider the realities facing children with Down Syndrome, Spina Bifida, Hemophilia and Cystic Fibrosis.

One infant in 1,000 is born with Down Syndrome, which translates into 4,000 to 6,000 births per year. Telephone interview with Diane Barounis, Resource Specialist for the National Down Syndrome Congress (July 18, 1989). These children are mentally disabled and often possess cardiac, musculo-skeletal, and gastrointestinal impairments. Repeated surgical procedures are often required to correct heart problems such as holes in the heart, incorrect circulation of blood, and heart murmurs and to repair club feet, dislocated hips, and other skeletal deformities.

The Center for Disease Control in Atlanta reports that 3000 children are born each year with Spina Bifida. Telephone inter-

view with Katherine Hartnett, Executive Director of the Spina Bifida Association of America (July 18, 1989). These children *all* encounter residual physical disabilities of varying degrees even after the spinal cord is surgically covered and reimplanted into the spinal column. Many children with Spina Bifida will be paralyzed in both legs, requiring the use of a wheelchair, walker, or braces. Nerve damage will create incontinence/retention of bladder and bowels, requiring colostomies and ileostomies for some children. Other children might require an indwelling tube (catheter) in their bladder or have to wear incontinence supplies, such as diapers.

Another problem associated with Spina Bifida is hydrocephalus, an abnormal collection of cerebrospinal fluid. Unless this condition is corrected by the placement of a tube in the brain (a shunt) to drain the excess fluid into the abdominal cavity, the head will enlarge and the child will suffer brain damage, including mental retardation. As the child grows, the shunt must be surgically replaced several times to allow for the increasing length of the neck and trunk. Shunts can also become plugged or infected, requiring further surgical intervention.

The Hemophilia Foundation reports that one in 4000 live male births results in a baby boy with the bleeding/coagulation disorder of Hemophilia. Chicago Tribune, Apr. 23, 1989, §10 (Magazine), at 12. Children with Hemophilia have varying degrees of the coagulation impairment ranging from mild to severe. A family with a child with mild Hemophilia pays on average \$2000 per year for treatment, while treatment for a child more severely affected costs on average \$18,000 to \$36,000 per year. Telephone interview with Chris Barnard, Social Work Coordinator for Hemophilia of Indiana, Inc. (June 28, 1989).

Cystic Fibrosis is the most common genetic disease affecting children. Cystic Fibrosis Foundation, *An Introduction to Cystic Fibrosis* 2 (1987). Approximately one child in 2,000 live births will be born with Cystic Fibrosis. *Id.* Ten million Ameri-

cans (one in twenty) are symptomless carriers of the Cystic Fibrosis gene. *Id.*

Cystic Fibrosis is a fatal disease, with a median age of death at twenty-seven years of age. Telephone interview with Jo Ann Dorgan, Assistant Director of Clinical Research, Cystic Fibrosis Foundation (July 18, 1989). It causes an abnormal accumulation of thick, sticky mucus that clogs the lungs and pancreas, interfering with breathing and digestion. Despite special diets, including enzymatic medications, and respiratory treatments several times a day that disrupt the usual life of a child, 95 percent of the children and young adults with Cystic Fibrosis ultimately die from respiratory complications. *Id.*

Children with disabilities constitute a large and increasing population of vulnerable persons. These children have many needs, and they often lack the means to meet those needs. The importance to society of providing children early health care cannot be overemphasized. Medical advances have made possible the inclusion of persons with disabilities into the mainstreams of society. Physical and mental disabilities no longer, practically speaking, should hinder a person from earning a living, practicing the arts or governing this nation. Yet, to participate when older, children with disabilities need early access to health care. Early treatment gives disabled children a needed head start to enter their adult years as productive members of society.

Indeed, the failure to assist young persons with disabilities is bad economics. The labor pool is shrinking as the current majority of the work force ages and more workers retire. According to Jay F. Rochlin, Executive Director of the President's Committee on Employment of People With Disabilities, "[d]emographics has given us a 20-year window of opportunity to institutionalize employment of people with disabilities. During that period, employers will be desperate to find qualified employees." Quoted in *As the Labor Pool Dwindles, Doors Open for the Disabled*, N.Y. Times, June 22, 1989, at 1, col. 1. Paul G. Hearne, Executive Director of the National Council on

Disability, recently told a conference on the disabled and the economy, "What I see now is policy makers and power brokers moving to integrate the disabled into the mainstream, to promote their independence, to make them people who pay taxes." *Id.* Unless children with disabilities obtain necessary health services when young, they may find it difficult or impossible to enter the workforce when older. The opportunity to become workers and taxpayers may then pass those children by — not because the opportunities won't be there, but because the early rehabilitative care wasn't financially obtainable when the children needed it most.

Because disabled children are vulnerable to discriminatory nontreatment, and treatment could rehabilitate these children to become productive members of society, the Secretary should assist these children — at the very least in a constitutionally legitimate and impact-neutral fashion.

III. The SSI Regulatory Scheme Increases the Risk of Discriminatory Denial of Health Services, Including Life-Sustaining Care, to Similarly Vulnerable Children.

The Secretary's Petition for Writ of Certiorari argues that "[t]he issue in this case is of considerable practical importance" because, among other things, "additional benefits . . . may have to be paid when a new standard is applied" to children already denied benefits under the existing standards. Petition for Writ of Certiorari, p. 17. In addition, implementing new standards "could be even more costly and time consuming." *Id.* at 18.

The import of this argument is not only constitutionally troublesome, but ethically appalling. For too long, persons with disabilities have encountered substandard care or received no care at all because of "costs." Children with disabilities often bear a double burden: the stigma of handicap and the inattention of those on whose care children must depend.

The ramifications of a restrictive SSI policy for children are

far-reaching and ominous. Discrimination against, even infanticide of children with disabilities is still pervasive, as the tragic history of the discriminatory, even lethal treatment accorded children with disabilities demonstrates: "Ancient [discriminatory] attitudes continue to have an impact on our notions of the value of disabled newborns [and children] and continue to play a role in their loss of life." Moseley, *The History of Infanticide in Western Society*, 1 *Issues in Law & Med.* 345, 361 (1986). Practices of and attitudes justifying discrimination against children with disabilities must be repudiated, not embraced.

Surveys of contemporary attitudes reflect a disturbing latent bias against children with disabilities, especially within the medical profession. "The data indicate that physicians generally have a pessimistic outlook about the life of a disabled newborn and generally acknowledge that there are circumstances in which nontreatment is justified. This is not the only attitude reflected in the surveys, but it is the dominant one." Turnbull, *Incidence of Infanticide in America: Public and Professional Attitudes*, 1 *Issues in Law & Med.* 363, 374 (1986). Physicians are significantly more pessimistic than psychologists, educators, allied health professionals, and social workers toward the prognosis for individuals who are, for example, mentally retarded. *Id.* at 376, citing Wolraich & Superstein, *Assessing Professionals Prognostic Impressions of Mental Retardation*, 21 *Mental Retard.* 8 (1983). Almost all groups in society, however, hold negative attitudes toward persons with disabilities. Richardson, "Reaction to Mental Subnormality," in *The Mentally Retarded and Society: A Social Science Perspective* 77 (M. Begab & S. Richardson, eds. 1975).

These negative attitudes may be the primary reason Down Syndrome children with leukemia are being refused bone marrow transplants, for example. A recent survey of bone marrow transplant centers in the United States found the number of Down Syndrome children receiving bone marrow transplants between 1979 and mid-1987 inexplicably low. Arenson & Forde,

Bone Marrow Transplantation for Acute Leukemia and Down Syndrome: Report of a Successful Case and Results of a National Survey, 114 *J. Pediatrics* 69, 72 (1989). According to Arenson and Forde, based on the reported incidence in the United States of acute lymphoblastic leukemia, 60 to 68 children with Down Syndrome could be expected during the 7 1/2 year period to have undergone bone marrow transplants. Yet the authors' survey of 58 transplant centers (96% of all centers treating children) indicated that only 16 Down Syndrome children in this period actually received transplants. *Id.*

The authors suggested the most likely reason for this gap was physician bias against Down Syndrome children:

The likelihood of parental refusal of bone marrow transplants is low unless the referring physician discourages the family. We cannot determine from available information why so few Down Syndrome children have undergone bone marrow transplants, but it seems reasonable to suspect that physician bias that Down Syndrome children are suboptimal candidates for bone marrow transplants has played a role. . . . Although Down Syndrome children may have an increased risk for acute pulmonary and infectious complications after bone marrow transplants, our survey suggests that Down Syndrome children who undergo bone marrow transplants have outcomes that do not differ significantly from those of normal children. We conclude that current experience does not justify denial of bone marrow transplants of acceptable candidates with Down Syndrome. In fact, denial of bone marrow transplants, based solely on the diagnosis of Down Syndrome (or any other handicap), is in conflict with federal guidelines for the provision of medical care to handicapped children.

Arenson, at 72.

In an accompanying editorial, the *Journal of Pediatrics* reflected on the study's suggestion that leukemia treatment centers may be discriminating against Down Syndrome children solely because of mental disability. Though holding it

would be "simplistic and erroneous to assume an overt prejudice against treating Down Syndrome children," the *Journal* was disturbed by the implications of what it deemed to be a more subtle, more potent form of bias:

Prejudice need not be conscious to be present. Unintended bias against Down Syndrome children can be all the more powerful for being unarticulated, especially among professionals who hold high ideals. . . . Very few individuals are expressly prejudiced against such patients, but many of us may be predisposed to believe the first evidence we read that Down Syndrome children will not do as well as others. Or we may be predisposed to over-generalize data collected from one group of patients to cover all patients when the results fit our assumptions or are otherwise convenient. Moreover, bias can be institutional, as opposed to personal. . . . Perhaps what Arenson and Forde have discovered is not a malign profession or callous parents but an unintended and powerful bias embedded in institutional practices — a prejudice all the more powerful because it is unacknowledged and difficult to examine, being cloaked in high ideals and having a professional imprimatur.

Churchill, *Bone Marrow Transplantation, Physician Bias, and Down Syndrome: Ethical Reflections*, 114 J. Pediatrics 87-88 (1989).

The *Journal* concluded that "[a]ctive advocacy at all levels is . . . required because we do not start from a neutral position, but from one already tilted toward a social judgment of persons with Down Syndrome and other handicaps as somehow less deserving of our efforts." Churchill, at 88.

The practice of medical decision-making based on the economic resources of a child's family and the economic policies of government is also all too real. A disturbing example is the nontreatment program initiated in 1977 at the Oklahoma Children's Memorial Hospital (OCMH), and reported in an article by Gross, Cox, Tatyrek, Pollay & Barnes, *Early Management and Decision Making for the Treatment of Myelomeningocele*,

72 Pediatrics 450 (1983). The article, written by members of a team of medical personnel responsible for recommending nontreatment, evaluated the program between 1977 and 1982.

The team at OCMH developed a selection process for deciding when to treat infants born with myelomeningocele, a genetic but treatable malformation of the spine. The physicians employed nonmedical criteria, including the socio-economic status of an infant's family and even the fiscal policies of the federal government. This criteria was used to determine whether an otherwise routine regimen of surgery and care should be recommended or discouraged for each infant. Parents of infants given "pessimistic assessments" were advised they could refuse all necessary surgery.

The OCMH selection team relied on a "quality of life" formula — $QL + NE \times (H + S)$ — first published in Shaw, *Defining the Quality of Life*, 7 Hastings Center Report 15 (1977). "In the formula, QL is quality of life, NE represents the patient's natural endowment, both physical and intellectual, H is the contribution from home and family and S is the contribution from society." Gross, at 456.

If the team subjectively considered the child's parents to have sufficient wealth, then the team recommended vigorous treatment. If the team concluded the parents did not meet the team's financial criteria, they advised "supportive care only." Supportive care purportedly was intended to keep the infant "comfortable" until death occurred. Routine corrective surgery was withheld. If hydrocephalus were present, then the cerebrospinal fluid was not drained, causing gross enlargement of the infant's head. Antibiotics and sedation were not prescribed. *Id.* at 452.

Similarly, the team considered "contribution of society" to be relevant to the children's interest in treatment or nontreatment. That is, the team believed cuts in governmental programs for children in some circumstances could render life-saving treatment for children with disabilities inadvisable:

We feel that at the present time society is giving a schizophrenic message to the families of patients with defective newborns. Groups supporting sanctity of life are insisting that all such babies be saved, and the federal government has recently adopted this stance by threatening the withholding of funds from hospitals in which such babies might be allowed to die. Parents are also informed that under Public Law 94-142, children have a right to an appropriate education tailored to individual needs. On the other hand, support for funding to finance medical needs is diminishing with attempts to cut government spending, and schools are struggling to provide the increased personnel necessary to comply with PL 94-142 as their budgets tighten. It is becoming easier to visualize a cruel irony in which maximum treatment would be mandated for newborns with myelomeningocele, but funding for their nurture later in childhood is unavailable. This would, in effect, be a delayed triage with no criteria except the availability of financing.

Gross, at 456.

The team asserted that "there is no evading the fact that external circumstances are crucially important in the outlook for the newborn with myelomeningocele. Thus, the treatment for babies with identical 'selection criteria' [i.e. medical indications favoring treatment] could be quite different, depending on the contribution from home and society." *Id.*

Indeed, the team proudly reported that "all 24 babies who continued to receive only supportive care [i.e., nontreatment] . . . died. These babies did not receive active treatment for infection and other acute illnesses." *Id.* at 453. But three of the five children recommended for supportive care and yet treated at their parents' insistence survived. *Id.* at 452.

A difference between the infants at OCMH recommended for treatment and those recommended for nontreatment often only was the economic status of the child's family. See Sherwood, *Take Two: Who Lives, Who Dies? — Part II*, Cable News Network Documentary, Radio-TV Monitoring Service, Inc.,

Transcript at 2 (February 22, 1984).

Systematic nontreatment of poor and disabled children such as reported at OCMH will only spread if the pool of children wrongly denied SSI benefits increases. The Secretary's capricious policies may become yet another "external circumstance" influencing physicians to make for disabled children what should be purely medical decisions.

The Secretary's policies may additionally influence parental attitudes to the children's detriment. Upon the birth of a child with disabilities, parents experience a range of emotions, both negative and positive. Evans, *The Psychological Impact of Disability and Illness on Medical Treatment Decision-Making*, paper delivered to conference sponsored by National Legal Center for the Medically Dependent & Disabled, Inc., on "Current Controversies in the Right to Live, the Right to Die; Legal, Medical and Ethical Issues," Washington, D.C., April 13, 1989. Financial worries are inevitably included in the mix of parental concerns. Maintaining a policy of strict medical eligibility, where adults are deemed eligible for SSI and therefore perhaps for Medicaid, while children with equal or greater functional impairments are nevertheless denied coverage, may impose a bewildering emotional burden on indigent parents. A repulsive option might then allure: consent to nontreatment not because treatment may be futile, but because ordinary and effective treatment is beyond the parents' financial reach.

Your amici thus fear that if the Secretary continues to deny SSI benefits to children disabled functionally, those children and others similarly situated will encounter an increased risk of denial of treatment based on non-medical, economic assessments by the medical profession in particular and society in general.

CONCLUSION

The Secretary's SSI eligibility process for children is constitutionally defective and detrimental to the interests of children with disabilities. For these reasons, your amici support the claims of Brian Zebley, Joseph Love, Jr., Evelyn Raushi, and the class of children they represent.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

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of Health and Human Services,**

Petitioner,

vs.

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Respondents.

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Court Of Appeals For The Third Circuit**

**BRIEF OF THE NATIONAL EASTER SEAL SOCIETY,
THE MUSCULAR DYSTROPHY ASSOCIATION,
THE NATIONAL DOWN SYNDROME CONGRESS,
VOICES FOR ILLINOIS CHILDREN, AND
PLAINTIFF CLASS MEMBERS IN *MARCUS V. SULLIVAN*,
NO. 85 C 453 (N.D. ILL.) AS AMICI CURIAE
IN SUPPORT OF RESPONDENTS**

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IN SUPPORT OF RESPONDENTS

INTERESTS OF AMICI

I. THE ORGANIZATIONAL AMICI

A. The National Easter Seal Society ("ESS"), founded in 1919, is a national direct service organization for persons with disabilities of all ages. It was the first organization established to help children with disabilities. Through local Easter Seal Societies in every state, ESS serves over one million persons each year. Annually, over 600,000 children receive Easter Seal services, including physical, occupational and speech-language therapies, psychological counseling, and health screening for potentially disabling conditions.

B. The Muscular Dystrophy Association ("MDA"), founded in 1950, is a voluntary national health agency that is dedicated to conquering 40 neuromuscular diseases that generally affect children and young adults. These diseases include the several muscular dystrophies, as well as various types of motor neuron diseases, inflammatory myopathies, and metabolic diseases of the muscle, among others. Through its worldwide research programs, its nationwide program of patient and community services, and its program of public education, MDA strives to help those with neuromuscular disease and their families.

C. The National Down Syndrome Congress ("NDSC"), founded in 1974, is the national advocacy organization of families of children with Down syndrome, and of professionals and interested other persons who provide services to or otherwise assist persons with Down syndrome. Through over 500 local parent support groups, the NDSC carries on a broad range of activities. These activities include advocacy to secure the rights of persons with Down syndrome, the provision of information and other assis-

tance to families of persons with Down syndrome to help them meet the special needs of these individuals, and the promotion of public understanding of persons with Down syndrome.

D. Voices For Illinois Children ("VIC") is a statewide children's advocacy organization governed by business, community and civic leaders. It works to improve the lives of children—especially poor children—in Illinois by, *inter alia*, bringing about significant changes in governmental policies and practices. VIC seeks to achieve such changes through research, policy analysis, public education, and community service.

ESS, MDA, NDSC, and VIC serve many children from low income families who are severely disabled and who (representatives of each of these organizations believe) are eligible for Supplemental Security Income ("SSI") benefits under Title XVI of the Social Security Act (the "Act"). Nonetheless, many of these children that amici serve have been denied such benefits under the Secretary of Health and Human Services' (the "Secretary's") regulations at issue here.

II. PLAINTIFF CLASS MEMBERS IN *MARCUS V. SULLIVAN*

Plaintiff class members in *Marcus v. Sullivan*, No. 85 C 453 (N.D.Ill.), include children in Illinois who are identically situated to the *Zebley* children before the Court in this case, in that they have been denied SSI benefits under the same regulatory scheme the *Zebley* children have successfully challenged. *Marcus v. Heckler*, 620 F. Supp. 1218 (N.D. Ill. 1985) (certifying class). In *Marcus v. Bowen*, 696 F.Supp. 364 (N.D.Ill. 1988), appeal pending, No. 89-2717 (7th Cir.), the court invalidated the Secretary's application of certain SSI eligibility regulations on

similar grounds to those that prompted the court of appeals below to invalidate the regulations at issue here.

This Court's decision in *Zebley* will almost certainly have a decisive impact upon the claims of the children class members in *Marcus*.

ARGUMENT

SUMMARY OF ARGUMENT

I. This case raises the question of whether the Secretary may deny a child's claim for SSI disability benefits without individually assessing the extent to which his impairment(s) limit his functional capacities. In defending his refusal to offer such individual functional assessments to children, the Secretary seeks to establish the principle that children claiming SSI are to be subject to a fundamentally different and much stricter eligibility scheme than are adults. Under the Secretary's scheme, only "some" impairments can trigger a finding of disability for a child, whereas "any" impairment can do so for an adult.

II. The Act includes four distinct requirements that forbid the Secretary from determining the eligibility of a child claiming SSI benefits other than by a system that measures the functional loss of all his impairments. First, the Act requires that he assess the "severity" of a child's impairments. 42 U.S.C. § 1382c(a)(3)(A). Second, it requires that he do so on an individualized basis. *Id.* ("if he suffers from any . . . impairment of comparable severity.") (emphasis added). Third, it provides that "any . . . impairment of comparable severity" must give rise to a child's eligibility. *Id.* (emphasis added). Finally, the Act provides that "the combined impact of the impairments shall be considered throughout the disability determination process." 42 U.S.C. § 1382c(a)(3)(F) (emphasis added).

The Secretary's method of determining eligibility for SSI child's disability benefits flouts these statutory requirements, which make eligibility turn on the functional loss a child's impairments impose on him. Under the Secretary's regulatory scheme, a child may establish his eligibility for SSI benefits only by showing that his impairment(s) meets or equals an impairment set forth in a "listing" of impairments. 20 C.F.R. § 416.924 (1988). However, the listings themselves (including only 184 impairments for adults and/or children) cover but a small fraction of the possible impairments or combinations of impairments from which a child may suffer. See, 50 Fed. Reg. 50068 (1985). The decisive point is that, for a variety of reasons, there is no way for the many children without any listed impairment or with combinations of impairments (no one of which meets the listings) to "meet" or "equal" the listings at all—*regardless of how severely they may be disabled by the impact of their impairments*. See e.g., Social Security Ruling ("SSR") 83-19 ("[I]t is incorrect to consider whether the listing is equaled on the basis of an assessment of overall functional impairment. . . . The functional consequences of the impairments . . . , irrespective of their nature or extent, cannot justify a determination of equivalence." SSR 83-19 (J.A. at 239-40) (emphasis in original)).

III. The Secretary's major defenses of his eligibility determination policy are all unpersuasive.

A. The central statutory directive here is that the "severity" of a child's impairments and those of an adult be "comparable." As even the Secretary acknowledges, this directive obliges similarity (between the directives being compared) as to at least "one or two salient points." Pet. Br. at 24. The Secretary's failure to consider the overall functional impact of a child's impairments upon him is a failure to undertake any comparison at all respecting

the singular "salient" feature of severity determinations under the Act: they are, by definition, functional determinations.

B. Contrary to the Secretary's contention, there would be nothing "unworkable" about a functional assessment standard that asks about a child's ability to perform age appropriate activities. The "ability to perform age appropriate activity" standard is precisely the general "benchmark" standard that the Secretary said would be appropriate in children's cases at the inception of the SSI program. Disability Insurance Letter ("DIL") III-11 (September 7, 1973); DIL III-11, Supplement 1 (January 9, 1974). Moreover, the Secretary's most recent revisions of the regulations confirm his view that the "age appropriate activities" benchmark for children is a workable analytic analog to the "ability to work" benchmark for adults. 20 C.F.R. § 416.994(c) and (c)(1)(ii) (1988).

C. The regulatory history establishes that, far from adopting his current policy contemporaneously with the Act, and pursuing it consistently since, the policy the Secretary announced at the inception of the Act—and pursued for at least six and one-half years thereafter—was very nearly the opposite of the one he now defends before this Court.

I.

INTRODUCTION

The Act establishes that a child will be eligible for benefits if he suffers from "any" impairment that is of "comparable severity" to one that would be disabling for an adult. 42 U.S.C. § 1382c(a)(3)(A). This case raises the question of whether the Secretary may deny a child's claim for SSI disability benefits without individually assessing the extent to which his physical and mental impairments limit his functional capacities.

The court of appeals below ruled that the Act, 42 U.S.C. § 1382c(a)(3)(A), did oblige such an individualized assessment of the functional impact of impairments, and it held that the Secretary's eligibility regulations transgressed this statutory directive. Appendix to Petition for Writ of Certiorari ("Pet. Ap.") at 2a, 17a.¹ In defending those regulations in this case, the Secretary seeks to establish the principle that children claiming SSI are to be subject to a fundamentally different and much stricter eligibility scheme than are adults. Under the Secretary's scheme, only "some" impairments that are of "comparable severity" to those that would be disabling for an adult can trigger a finding of disability for a child. These are the impairments that he determines to meet or "medically equal" his limited listing of impairments. 20 C.F.R. § 416.924 (1988). See § II.B., *infra*. Children with "other" impairments are simply found "not disabled," without any assessment of the overall functional severity of their impairments at all.

II.

THE SECRETARY'S METHOD OF DETERMINING ELIGIBILITY FOR SSI CHILD'S DISABILITY BENEFITS VIOLATES THE SOCIAL SECURITY ACT.

A. The Act Requires The Secretary To Adjudge Children's Eligibility By Individually Assessing the Functional Impact of Each Child's Impairments Upon Him.

Title XVI defines the eligibility of children for SSI benefits as follows:

¹ The court of appeals did not "jettison the entire regulatory framework", as the Secretary asserts. Brief for the Petitioner ("Pet. Br.") at 42. The court did not invalidate any particular regulation, but focused on an *omission* in the regulatory scheme.

An individual shall be considered to be disabled for purposes of this subchapter if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, *in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity.*)

42 U.S.C. § 1382c(a)(3)(A) (emphasis added). This definition is the basis for three statutory requirements that are central to the case: that disability will be found if impairments have a "severe" enough impact upon the child's functional capacities; that "any" impairment that is "severe" enough will be the basis of a finding that disability exists; and that the Secretary will assess each claimant individually to determine whether "he" has "any" impairment that is "severe" enough to be disabling. The Act also establishes a fourth requirement important here: that the Secretary must assess the combined impact of all of each claimant's impairments. 42 U.S.C. § 1382c(a)(3)(F).

1. The term "severity" in the definition of disability requires the Secretary to assess the impact of a child's impairments upon his functional capacities. The textual referent of the phrase "comparable severity" is to the "severity" of impairments that disable an adult. The Act defines the level of impairment severity that disables an adult in functional terms: it is the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment . . . [The impairment must be] of such severity that [the claimant] is . . . unable to . . . work." 42 U.S.C. §§ 1382c(a)(3)(A) and (B). "Severity" is thus a matter of the degree to which an adult's ability to engage in work-related activities is limited—or, in the case of children, the degree to

which their functional abilities are "comparably" limited. See, *Bowen v. Yuckert*, 482 U.S. 137, 146 (1987) (Act takes "functional approach" in defining disability). See also, 5 Fed. Reg. 33238, 33241 (proposed August 14, 1989) (children's mental impairment listings):

"In childhood cases, as with adults, severity is measured according to the functional limitations by the medically determinable . . . impairment."

2. The statute also says that it is "any . . . impairment of comparable severity" that should give rise to a child's eligibility for benefits. 42 U.S.C. § 1382c(a)(3)(A) (emphasis added). "Any" impairment(s) that results in "severe" enough limitations upon the child's functional capacities must be the basis of a disability finding.² The Secretary may not (as he has, see § II.C., *infra*) implement a scheme for determining children's disability in which only "some" impairments can result in a finding of disability.

3. The Act's definition provides for individualized determinations of disability, not for generalized "average child" or "most children" determinations. "[I]n the case of a child . . . , if he suffers from any medically determinable physical or mental impairment of comparable severity." 42 U.S.C. § 1382c(a)(3)(A) (emphasis added). The statutory

² The Secretary, plainly bothered by the word "any" in the statute, says that it is a "slender statutory reed" on which to invalidate the Secretary's regulations. Pet. Br. at 19. Labels like that are not helpful. Congress used the word "any" in the statute to modify "impairment" and, as in the federal welfare statute at issue in *Shea v. Vialpando*, 416 U.S. 251 (1974), it presumably meant that word to carry its usual and ordinary meaning of "all." See, *id.* at 260 (When statute required state agency to consider "any" expenses attributable to the earning of income in determining eligibility of families with children under federal-state welfare program, state was required to consider "all" such expenses, not just some of them).

directive in this respect is the same as it is for adults, as to whom the statute provides that "an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity" 42 U.S.C. § 1382c(a)(3)(B) (emphasis added). The measurement of functional loss must therefore involve an "individualized determination[]." *Heckler v. Campbell*, 461 U.S. 458, 467 (1983).

4. The Act provides that "the combined impact of the impairments shall be considered throughout the disability determination process." 42 U.S.C. § 1382c(a)(3)(F) (emphasis added). Only through an assessment of each claimant's overall functional loss can the Secretary consider the combined impact of all impairments. The claimant's overall functional loss necessarily represents the sum of the effects of all of his impairments.

In sum, the Act includes four distinct requirements that forbid the Secretary from denying a child's claim for SSI benefits without measuring the functional loss of his particular impairments. As we discuss in § II.B., *infra*, however, the Secretary has adopted a disability determination system for children that does not offer the requisite individualized functional assessment—and so transgresses each of these statutory directives.

B. Under The Secretary's Method Of Determining Eligibility, Many Children Are Denied SSI Disability Benefits Without Having Received an Individualized Assessment Of The Functional Impact of Their Impairments Upon Them.

1. The Secretary has determined that a child may establish his eligibility for SSI benefits only by showing that his impairment(s) meets or equals an impairment set forth in a "listing" of approximately 184 impairments. 20 C.F.R. § 416.924 (1988). See, 20 C.F.R. Part 404, Subpart P, Ap-

pendix 1 (setting forth the listings) (J.A. at 115-235).³ Each "listing" is a specification of those medical criteria—signs, findings, and symptoms—respecting a particular impairment that a claimant with that impairment must meet or equal in order to be determined disabled. *Id.* More specifically, the Secretary presumes that any claimant who has an impairment that meets or equals a listing has a degree of functional loss "severe" enough to be disabling under the Act. 44 Fed. Reg. 18170, 18170-1 (1979). *See, Bowen v. City of New York*, 476 U.S. 467, 470-1 (1986).

For a child to "meet" a listing, he must establish that the medical findings respecting his impairment match or exceed each of the listed criteria for that impairment. SSR 83-19 (J.A. at 236-38). For a child to "equal" a listing, he must establish that the medical findings respecting his unlisted impairment or combination of impairments are equivalent to or exceed each of the listed criteria for one of the listed impairments—that is, they are alike in kind, duration and severity. SSR 83-19 (J.A. at 238-40).

The Secretary's requirement that children have an impairment that either meets or equals a listing in order to be eligible for benefits does not provide most children any individualized assessment of the functional impact of their impairments. There are a great many impairments and combinations of impairments that children have that do not meet or equal the listings, but that can have a "severe" enough impact upon a child's functional capacities to be disabling under the Act. The scheme does not allow a child to be eligible for benefits as the result of "any" impairment that is of the requisite "severity".

³ There are actually two listings for children. The Part A listings (at 20 C.F.R. Part 404, Subpart P, App. 1, §§ 1.00-13.00) apply to adults and children; the Part B listings (at 20 C.F.R. Part 404, Subpart P, App. 1, §§ 100.00-113.00) apply to children alone. 20 C.F.R. § 416.925 (1988).

a. The listings themselves cover only a small fraction of the possible impairments a child may have. The Secretary himself has consistently acknowledged that the listings are not meant to include and do not include most medical impairments. *See*, 50 Fed. Reg. 50068, 50069 (1985) (While the "listing includes medical conditions frequently diagnosed for people who file for disability benefits . . . [it] does not include all impairments."). Only approximately 184 impairments are listed. In contrast, the Merck Manual, an authoritative source of medical information, lists 21 categories of disorders, and most categories include dozens of impairments. The Merck Manual (R. Berkow and J. Talbott, Eds. 13th Ed. 1977). *See, id.* at 1313-15 (listing 125 different rheumatoid disorders). Similarly, the Diagnostic and Statistical Manual of Mental Disorders III-R ("DSM III-R") lists at least 48 mental disorders that normally are evident only in infancy, childhood or adolescence. American Psychiatric Association, DSM III-R at 25-95 (3rd Ed. Revised 1987). There are hundreds of other mental disorders that affect children as well as adults. *Id.* at 555-67. Another indication of the limited nature of the Secretary's listing of impairments can be found in the regulations of the Veterans Administration. The listing of impairments for the veterans disability programs includes over 700 impairments. 38 C.F.R. Part 4, Subpart B, §§ 4.40 *et seq.* and App. C.⁴

⁴ Amicus MDA serves claimants whose impairments implicate a particularly dramatic example of the limitations of the listings. Muscular Dystrophy ("MD") is not found in the special children's listings. The adult listing sets forth one set of criteria for the disease. 20 C.F.R. Part 404, Subpart P, Appendix 1, § 11.13 (J.A. at 178). However, there are many different forms of MD (*E.g.*, Duchenne's, Becker's, Facioscapulohumeral, Limb-girdle, Ocular, Gower's, Steinert's), and there are numerous related neuromuscular disorders. Merck Manual at 1475-79. These each impose different functional limitations upon children, and many of these are not related to the listed criteria. *E.g., id.* at 1478-79.

By the same token, the listings are not meant to include and could not realistically include all the combinations of impairments from which a child might suffer. Thus, even if the 184 medical impairments in the listings were the only impairments in the world, the number of possible combinations of these impairments that a particular child might have would be vast (theoretically, at least, equal to the product of $184 \times 183 \times 182 \dots \times 3 \times 2 \times 1$).

The listings include only a small fraction of the impairments and combinations of impairments that are severe enough to disable a child. A finding that a child does not suffer from a listed impairment, while answering the question of whether he "meets" the listings, therefore does not answer the question of whether he is disabled under the Act. Under the Secretary's regulations, a child cannot "meet" the listings if he does not have an impairment that is on the list. Even if the process of determining whether a child's listed impairment "meets" listed severity criteria can be said to constitute the individualized assessment of functional limitation required by the Act (as the Secretary insists), it plainly only does so for children who have solely a listed impairment.

b. The Secretary has promulgated the "equals" concept as the sole means for children without a listed impairment to prove disability. Under the equals concept, the Secretary "will decide that [a claimant's] impairment(s) is medically equivalent to a listed impairment . . . if the medical findings are at least equal in severity and duration to the listed findings." 20 C.F.R. § 416.926(a) (1988). Arguably, this formulation on its face could call for a comparison of the severity of the functional impact of the claimant's impairments with the functional severity level

exemplified by the listed impairments.⁵ This is not, however, what the Secretary requires or allows under his authoritative interpretation of the equals concept in SSR 83-19 (J.A. at 236-43).

Under SSR 83-19, the equals concept is in fact quite the opposite of one that ensures an assessment of the functional impact of "any" impairment, i.e., of all unlisted impairments or combinations of impairments. The Ruling states: "[I]t is incorrect to consider whether the listing is equaled on the basis of an assessment of overall functional impairment. . . . The functional consequences of the impairments . . . , irrespective of their nature or extent, cannot justify a determination of equivalence." SSR 83-19 (J.A. at 239-40) (emphasis in original). The Secretary thereby forbids any "equals" finding based upon an individualized assessment of functional limitation. No unlisted impairment and no combination of impairments can ever be the subject of an assessment of its functional impact upon a child. No child with such an impairment or combination of impairments can be found disabled based upon the

⁵ By calling for a comparison of impairment "severity", the regulation invokes the statutory term that is the basis for the requirement of a functional assessment. See § II.A.1., *supra*. The equals concept regulation is thus capable of a reading that would provide the individualized functional assessments that the court of appeals held to be fatally lacking in the regulatory scheme. See, *Tolany v. Heckler*, 756 F.2d 268, 272 (2d Cir.1985) (requiring functional assessment to determine medical equivalence without questioning the facial validity of the regulations); *Williams v. Bowen*, 636 F.Supp. 699, 704 (N.D. Ill.1986) (same); *Taggart v. Heckler*, 576 F.Supp. 624, 627 (W.D.Ark.1984) (same). The Secretary's repeated insistence that the court of appeals facially invalidated the regulations is thus not only contrary to the text of the decision (finding the omission of a functional assessment to be fatal), it is in no way necessitated by the decision.

"severity" of the functional limitations caused by the impairment(s).⁶

To be sure, some claimants may, under SSR 83-19, be found eligible under an "equals the listings" analysis—but for reasons other than the functional limitations imposed by their impairments (since SSR 83-19 forbids an eligibility finding on this basis). The vice of the equals concept under SSR 83-19, however, is that most children claimants with unlisted impairments and combinations of impairments that result in functional limitations "severe" enough to be disabling will be found *not* to equal a listing, and will be denied benefits.⁷

⁶ The Secretary's restriction of the "equals concept in SSR 83-19," has transformed the equals concept from one under which almost half of all successful disability claimants established their eligibility to one under which substantially fewer do. Out of all favorable Title II decisions, "equals" constituted 43.9% while "meets" constituted 29.4% in 1975. "Equals" exceeded "meets" by 45.1% to 29% in 1976, and 41.9% to 34.2% in 1977. In 1980, the year that the policies embodied in SSR 83-19 became effective (See § II.C.4., *infra*), "meets" exceeded "equals" by 57.9% to 16.2%. "Equals" determinations were only 8.6%, 8.3%, 8.7%, 9.2%, 8.7%, 10.2%, and 11.0% of all favorable Title II decisions during 1982-1988 inclusive. Committee on Ways and Means, U.S. House of Representatives, "Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means", Section II, Table 2 (March 15, 1989).

⁷ These are the children this case concerns. It thus does the Secretary no good to claim that his disability determination scheme provides an assessment of functional loss as to *some* impairments—the listed impairments in the special Part B listing for children in particular. Pet. Br. at 18. The children with such listed impairments are not mainly the ones who are injured under the Secretary's scheme. Respondents and the court of appeals were and are concerned with the much greater number of children *without* listed impairments who, for the reasons reviewed in § II.B. are not afforded an individualized determination of the functional severity of their impairments, and are, as a result, denied disability benefits to which they are statutorily entitled.

Two distinctive features of SSR 83-19, and two related examples, illuminate the precise nature of this vice. First, SSR 83-19 requires the medical findings relative to the claimant's impairments to be compared to the medical criteria in one listed impairment. The claimant's impairment must equal each of the listed criteria in order to satisfy the equals concept, *regardless* of the intensity of the findings as to any one of the listed criteria. "The level of severity in any particular listing section is depicted by the *given set* of findings and not by the degree of severity of any single medical finding—no matter to what extent that finding may exceed the listed value." SSR 83-19 (emphasis in original) (J.A. at 239). For example, the listing for juvenile rheumatoid arthritis calls for a number of criteria to be met, including "limitation of motion of two major joints of 50% or greater." 20 C.F.R. Part 404, Subpart P, Appendix 1 (1988) (J.A. at 209). If the child has limitation of motion in one major joint of 40% and in another major joint of 80%, he will not have met or equalled the listing, even if he has met or equalled all of the other listed criteria (e.g., joint inflammation, specific documentation of diagnosis). If the child has limitation of motion in each of two major joints of 80%, but does not equal all of the other criteria of the listing, he will not have satisfied the equals concept. In neither case will the Secretary consider the impact of the substantially greater limitation of range of motion upon the child's functional capacities, or, therefore, whether the functional limitations are "severe" enough to be disabling.

Second, SSR 83-19 requires that, for claimants with multiple impairments, adjudicators must identify the one listed impairment that is the same or closest to the claimant's most severe impairment. (J.A. at 240). Then the "set of symptoms, signs, and laboratory findings" for the claimant's various impairments are evaluated to determine

whether "combined, [they] are . . . medically equivalent in medical severity to that listed set to which the combined sets can be most closely related." (*id.* at 239). Assume that a child's most severe impairment is juvenile rheumatoid arthritis, and that she also suffers from borderline mental retardation and a heart condition. She has limitation of motion in two major joints, but only of 40% in each (50% would meet the listing). Under SSR 83-19, the equals determination consists of deciding whether the medical findings relative to the mental retardation and heart condition somehow "make up for" or "constitute" the extra ten percent range of motion limitation that would have allowed the child to meet the juvenile rheumatoid arthritis listing. The determination must be made without the forbidden assessment of overall functional loss. Only the "values" of the medical findings are compared. (Does an IQ of 72 equal a 10% limitation in motion?)⁸ Determinations under this method, made without the common denominator provided by a functional assessment, are extremely difficult and result in inconsistent adjudication. Fox, H., and Greaney, A., *Disabled Children's Access to Supplemental Security Income and Medicaid Bene-*

⁸ The example does not portray the substantial problems that often arise when the adjudicators try to select the one impairment that is the most severe (in order to select the appropriate listing for comparison), or when adjudicators must select a listed impairment when the claimant's impairments offer no clear comparison or suggest more than one comparison. These problems implicate the outcome of each case. They create substantial inconsistencies in adjudication. See, *Marcus*, 696 F.Supp. at 378-79 n.18 (quoting the Secretary's own Quality Assurance Review dated April 27, 1984, which cites a high incidence of adjudicatory error "related to the inherent difficulty of evaluating and then combining the severity of several impairments . . . and to the inadequate policy guides which direct a physician to compare two dissimilar impairments to the listing most closely related to them. Unless one of the multiple impairments is clearly predominant, this comparison is not practical, especially when dealing with the situation in which a combination of exertional and nonexertional restrictions is present.").

fits ("Fox and Greaney"), Fox Health Policy Consultants, Inc., Washington, D.C. at 52-54 (December 1988) (copy lodged with the Court's clerk).

The sort of determination required by SSR 83-19 simply does not answer the question of what the child can do despite his combined impairments. See, Fox and Greaney at 58-61. Many children who are not found disabled under the equals concept suffer from impairments that, in combination, are severe enough that they are, in fact, statutorily disabled. Stopping the disability determination after applying only the meets or equals test denies these children the statutory right to be found eligible if disabled by "any" impairment.⁹

⁹ The shortcomings of the equals concept under SSR 83-19 fall particularly hard upon the children whom amicus NDSC serves: children with Down syndrome. Down syndrome is not a listed impairment, having been removed from the original listings because it allegedly has no standard manifestation and can be evaluated under listings for various body systems. 42 Fed.Reg. 14705, 14707 (1977). Relatively recently, however, the Secretary proposed listing criteria for Down syndrome. 52 Fed. Reg. 37161 (proposed October 5, 1987). These criteria, which the Secretary has not adopted, would establish the basic disabling criterion for Down syndrome to be "significant interference with age-appropriate major or daily personal care activities;" and they emphasize the likelihood that multiple body system impairments will have to be evaluated in combination to determine whether they are equal in severity to the listed criterion. *Id.* at 37162. Indeed, while Down syndrome is present when it is confirmed that a child has extra chromosome material, there may be as many as 300 different clinical signs that manifest themselves among persons having the impairment. Cunningham, C., *Down's Syndrome: An Introduction for Parents*, 102 (2nd Ed., 1988). Therefore, children with Down syndrome must depend heavily on proper analysis of combined impairments in order to prove eligibility for SSI benefits when no single one of their clinical manifestations meets a listing for the applicable body system. A great many of these children will not satisfy the Secretary's very narrowly defined equals concept for combined impairments. They have no chance to prove that they are disabled by the functional limitations imposed by their collective impairments.

(Footnote continued on following page)

C. Neither The "Statutory Language" Nor Any "Functional Considerations" In The Listings Save The Secretary's Eligibility Determination Method, And This Method Is Not Entitled To Any Deference.

The Secretary offers four major defenses of his policy of denying children's disability claims without assessing the individual's overall functional loss. He argues that the "statutory language" supports his policy. Pet. Br. at 27-30. He says that the listings are not "divorced from functional considerations." Pet. Br. at 42. See *id.* at 28. He insists that the functional assessment respondents seek and the court of appeals required is "wholly unworkable." Pet. Br. at 43. See also *id.* at 43-44. Finally, he defends his regulations as based on a contemporaneous and longstanding interpretation of the Act, entitling them to considerable deference. Pet. Br. at 35-8. None of these four defenses are persuasive.

1. The Secretary distorts and misreads the statutory language.

a. The Secretary says that "Congress did not direct that the severity of impairments for adults and children be identical, only that they be 'comparable'", and that

⁹ *continued*

Down syndrome is just one of thousands of unlisted impairments, and yet there are approximately 54,000 children (under 18) with Down syndrome in the United States. Adams M., et al., *Down's Syndrome: Recent Trends in the United States*, J. A.M.A. Vol. 246, No. 7, at 759, table 3 (August 14, 1981) (approximately 4,000 births per year); and Baird, P. and Sadovnick, A. *Life Expectancy in Down Syndrome Adults*, *The Lancet*, December 10, 1988, at 1355, Fig. 2 (approximately 75% of children born with Down syndrome survive to age 18). (Thus $4,000 \times 18 \times .75 = 54,000$). The scope of the numbers of children denied a proper evaluation of their impairments by the Secretary's regulatory scheme is thereby manifest, even assuming (conservatively) that no more than a few thousand of the 54,000 children with Down syndrome are financially eligible for SSI benefits.

that term "does not require complete similarity." Pet. Br. at 24. That is true. But whatever leeway the word "comparable" provides the Secretary with respect to the establishment of the level of "severity" that he will acknowledge as disabling as between adults and children, it does not permit him any leeway at all regarding the statutory requirement that a child may be disabled based on "any" impairment that has the requisite severity level. "Comparable" modifies "severity", not anything else. It certainly does not modify the requirement that the Secretary consider the combined impact of all impairments, which is found in an entirely different section of the Act, 42 U.S.C. § 1382c(a)(3)(F).

Moreover, as the Secretary acknowledges, the term "comparable" does oblige similarity (between the directives being compared) as to at least "'one or two salient points.'" *Id.*, quoting *Webster's Third New International Dictionary* at 461 (1976). The statutory directive here is that the "severity" of a child's impairments and those of an adult be "comparable." The Secretary's failure to consider the functional impact of a child's impairments upon him is a failure to undertake any comparison at all respecting the singular "salient" feature of severity determinations under the Act: they are, by definition, functional determinations. In other words, as "severity" is a measure of functional limitation in adults, it cannot be made into other than a functional measure in children. That is what the Act means by "comparable severity": comparable measures of functional limitation.

b. The Secretary points out that when 42 U.S.C. § 1382c(a)(3)(A) requires that an adult claimant be unable to engage in substantial gainful activity "by reason of" his impairment, it is referring to the consequences of that impairment. Pet. Br. at 25. In contrast, he says, the statute contains no express reference to a child's disability

being "by reason of" his impairment, only that the impairments be of "comparable severity" to ones that would disable an adult. *Id.* The Secretary concludes from this language that the "consequences" of a child's impairments—that is, the functional impact of his impairments—are irrelevant in determining his eligibility. This argument asks far too much of the statutory language, and asks even more from the absence of statutory language. Among other things, the argument ignores the fact that the basis for functional assessments in the disability definition comes from the word "severity" and its textual context, not from the words "by reason of." It also ignores the fact that the Act separately requires consideration of the "combined impact" of all impairments. 42 U.S.C. § 1382c(a)(3)(F) (emphasis added).

c. The Secretary says that the "pivotal term 'severity' has been used by the Secretary and Congress under the Social Security disability programs to refer to a *medically* severe impairment, the degree of which is based on medical evidence alone." Pet. Br. at 25. (emphasis added). He suggests that the court of appeals' ruling would require the Secretary to evaluate children's eligibility by reference to "'nonmedical factors such as education and experience.'" *Id.*, quoting *Bowen v. Yuckert*, 482 U.S. at 149 n.7. But the court of appeals ruling clearly anticipates no such result. The ruling would oblige the Secretary to determine what a child whose impairments do not meet or equal a listing can do in spite of his impairments. When he makes this type of determination in adult cases, the Secretary says he is determining the residual functional capacity ("RFC") of the claimant. The Secretary's own regulations provide that "[r]esidual functional capacity is a *medical* assessment." 20 C.F.R. § 416.945 (1988) (emphasis added). See, SSR 83-10 (same). See also, 20 C.F.R. § 416.946 (1988) (referring to RFC determinations as be-

ing based on "all the medical evidence we have."').¹⁰ The assessment the Secretary must make under the court of appeals ruling is, in short, a "medical only" assessment. See, Pet. App. at 17a (Secretary must afford children "the opportunity for individual evaluations comparable to the residual functional capacity assessment for adults.').

d. The Secretary points out that subparagraph (B) of 42 U.S.C. § 1382c(a)(3), "does not identify any non-medical factors that must be considered on an individualized basis in children in the same manner that an adult's age, education, and work experience are taken into account." Pet. Br. at 29 (emphasis added). He contends further that it is this language in subparagraph (B) that requires him to make functional assessments for adults, and that the absence of any "comparability" clause in that provision, among other factors, undermines any contention that the Secretary must offer the children here any "comparable" assessment of the functional impact of their impairments. *Id.* at 30. He makes the related suggestion (Pet. Br. at

¹⁰ In referring to RFC in his brief, the Secretary consistently characterizes it as involving an assessment of "non-medical" factors. *E.g.*, Pet. Br. at 18, 26. In light of the express language in his own regulations and rulings, that characterization is untenable. Moreover, several of the listings themselves incorporate functional assessments as to elements of the listed criteria. *E.g.*, § 10C (inability to use a prosthesis effectively) (cited as functional criterion by Secretary in SSR 33-19). (J.A. at 122, 238); 54 Fed. Reg. 33238 (proposed Aug. 14, 1989) (Proposed children's mental impairment listings adopt functional approach to assessing even listed mental impairment). The Secretary correctly insists that the listings consist of "medical only" factors. It follows that functional factors, by virtue of their presence in the listings, are medical factors. Finally, this Court in *Yuckert* upheld the Secretary's "medical only" threshold severity step in the sequential evaluation process in part because it conformed to the Act's requirement of a "functional approach" to eligibility determinations. *Yuckert*, 482 U.S. at 146. This Court has thus acknowledged that under the Act "function" is a "medical" consideration.

28-29) that the absence of any specific reference to "children" in subparagraph (B) indicates that Congress did not mean children to receive such a functional assessment.

However, the requirement that the Secretary determine a child's eligibility by individually assessing the functional impact of his impairments upon him is grounded in the Congressional direction—in subparagraph (A)—that the Secretary determine the "severity" of a child's impairments. See § II.A.1., *supra*. The absence of a comparability clause in subparagraph (B) is therefore of no account here. Moreover, the word "severity" is not used in subparagraph (A) with respect to adults, but only in subparagraph (B). Thus the term "comparable severity" used in subparagraph (A) with respect to children necessarily incorporates the adult "severity" definition contained in subparagraph (B). Further, Congress introduced subparagraph (B) with the phrase, "for purposes of subparagraph (A)," indicating that the dictates of subparagraph (B) were to guide the determination of "severity" (including "comparable severity") under subparagraph (A). As for the fact that "children" are not specifically mentioned in subparagraph (B), they are not specifically mentioned in 42 U.S.C. § 1382(a)(3)(F)(G) and (H) either. These provisions require the Secretary, *inter alia*, to consider the combined impact of claimants' impairments when determining their eligibility, to adopt "uniform standards" to govern disability determinations, and to apply a "medical improvement" standard when terminating disability benefits. If subparagraph (B) does not apply to children (because it does not specifically refer to them), then, by the same logic, these succeeding provisions would not apply to children either—an obviously preposterous result.

2. The Secretary's vigorous insistence that the listings are "not divorced from functional considerations," Pet. Br. at 42, appears designed to advance the argument that,

while few, if any, children claiming SSI receive an individualized functional assessment of the overall impact of their impairments, all children claiming benefits receive *some* type of individualized functional assessment by means of an "individualized" determination of whether they meet or equal the listings. See Pet. Br. at 27.

Amici do not quarrel with the proposition that some listings "take into account functional . . . consequences of impairments . . ." *Id.* But the great majority of children are those with unlisted impairments or combinations of impairments. An assessment of whether they meet the functional component of a listed impairment that is not their only impairment, or that they do not suffer from at all, does not answer the question of what functional capacities they retain despite the impairments that they do have. These children will be denied benefits even if their impairments are of disabling severity. By performing an assessment that includes something he can label "functional", the Secretary does not disguise the fact that the assessment is not adequate under the Act.

3. There would be nothing "unworkable" about a functional assessment standard that asks about a child's ability to perform age appropriate activities. As amici note *infra* (in § II.C.4), the "ability to perform age appropriate activity" standard is precisely the general "benchmark" standard that the Secretary said would be appropriate in children's cases at the inception of the SSI program. Indeed, the Secretary's most recent revision of the regulations confirms his view that the "age appropriate activities" benchmark for children is the analytic analogue to the "ability to work" benchmark for adults. Specifically, the regulations the Secretary has promulgated to comply with the Disability Reform Act of 1984, define a child's continuing eligibility for SSI partly in terms of whether there has been any "medical improvement" in the claim-

ant's "impairments." The regulations instruct SSA decision-makers that, if there has been medical improvement, they should determine whether "this medical improvement is related to . . . [claimant's] ability to work (i.e. . . . *[his] ability to perform age appropriate activities*)." 20 C.F.R. § 416.994(c) and (c)(1)(ii) (1988) (emphasis added). To be sure, the question of whether a child is able to perform age appropriate activities is but a general "benchmark standard," a common denominator for evaluating the disabling severity of any impairment or combination of impairments. The Secretary might also wish to develop specific implementing criteria relating specific ages, abilities, and levels of limitation. This would be a complex task. But he has developed this sort of implementing criteria before, such as the detailed and sophisticated set of criteria that implement the application of the vocational factors in adult cases (the "grids"). See, *Heckler v. Campbell*, 461 U.S. 458 (1983). The Secretary, who does not even acknowledge his obligation to conduct functional assessments in children's cases, has, of course, never undertaken the effort of developing either a benchmark or implementing severity criteria for children (with unlisted impairments or with combinations of impairments). See, *Marcus*, 696 F. Supp. at 380-81.¹¹ He can therefore hardly be heard to complain either that no such criteria exist, or that he would be unable to develop them if he tried.

4. If the Secretary's regulations do not conform with the Act, they must fall regardless of whether they reflect a consistent and long-standing policy. *Mohasco Corp. v. Silver*, 447 U.S. 807, 825 (1980). In any event, the story the Secretary tells (Pet. Br. at 35-41) about his allegedly

¹¹ The proposed children's mental impairment listings contain age-appropriate functional activity levels for each impairment, but not for overall functional activity. 54 Fed. Reg. 33238 *et seq.* (proposed August 14, 1989).

"contemporaneous" and longstanding interpretation of the Act is belied by the regulatory history.

In September 1973, three months prior to the effective date of the SSI program (January 1, 1974), the Secretary issued to state disability adjudicators charged with administering the program a pre-regulatory directive that stated:

Historically, the term "disability" has, under Title II, been associated exclusively with an inability to work, which is a primary activity of adults. This term, when applied to children, cannot properly be associated with an inability to work, since children are not ordinarily expected to engage in such activity. Accordingly, disability in children must be defined in terms of the primary activity in which they engage, namely growth and development, the process of maturation. Additionally, children even with the same diagnosed disease as an adult, may have different pathophysiologic manifestations of that disease, and the impact of the disease may be different. . . .

These factors make it impossible to compare directly the severity of the child's impairment with that of an impairment which would prevent an adult from engaging in SGA; thus in applying the [eligibility] guides [for children], "comparable severity" means that the severity of the impact of the child's impairment(s) must be "comparable" to the severity of the impact of an impairment(s) which would prevent an adult from engaging in any substantial gainful activity."

DIL III-11 (J.A. at 90-91) (emphasis added, except as to phrase "of the impact").

Two features of DIL III-11 particularly distinguish it, given the Secretary's insistence that the policy he defends here is one he adopted at the inception of the SSI program. First, it emphasizes the necessity for an assessment of the functional "impact" of a child's impairments. Second, the directive reflects the Secretary's recognition that

the anomaly of applying an "inability to work" test for children obliged him to develop a benchmark standard for children (analogous to the "inability to work" standard for adults) that would permit an individualized functional assessment of their impairments. The Secretary described this benchmark in precisely the terms he now disparages: the ability of children to perform age appropriate activities. ("[D]isability in children must be defined in terms of the primary activity in which they engage, namely growth, and development, the process of maturation.")

After the SSI program became effective, the Secretary issued a Supplement to DIL III-11. In DIL III-11, Supplement 1 (January 9, 1974) (J.A. at 94-114), the Secretary emphasized the importance of the equals concept not only in assessing impairments that are not listed, but in assessing combinations of impairments where no single one of them meets a listing: "Each impairment must have some substantial adverse effect on the child's major daily activities, and together must 'equal' the specified impact." *Id.* at 97. This is a description of the functional assessment the Act requires; the claimant's total functional loss is compared to a specified level of functional loss that the Secretary has established as the disabling level (the level exemplified by the listed impairments). The Supplement thus reaffirmed and clarified the notion that the equals concept was the mechanism to ensure to every claimant a functional assessment consistent with the Act.

On March 16, 1977, the Secretary promulgated the first final regulations governing the children's disability program, including the new children's listing of impairments. 42 Fed. Reg. 14705 (1977). He adopted the equals concept intact from the Title II wage earner program, adding only that he would determine equivalence "with appropriate consideration of the particular effect of disease processes in childhood." *Id.* at 14708 (emphasis added). This was a

reaffirmation that the equals concept would examine functional limitations in children.

On August 20, 1980, the Secretary promulgated an amendment to the equals concept. 45 Fed. Reg. 55566, 55566-67 (1980), codified as 20 C.F.R. § 416.926. He maintained, however, that the amendment incorporated no change in policy respecting medical equivalence. 45 Fed. Reg. 55566, 55576 (1980).

The Secretary's representation to the contrary, SSR 83-19 discloses that the 1980 regulatory amendment was in fact meant to effect a change in policy. As we have explained (at § II.B.1.b, *supra*) this ruling, far from ensuring an individualized assessment of the functional impact of "any" impairment a child has, thus expressly forbade such an assessment. It also stated that "[t]he policy explained herein was effective August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566)". (J.A. at 243).¹²

The change in policy under the 1980 regulatory amendment (via the 1983 ruling, SSR 83-19) completely reversed the Secretary's prior and contemporaneous understanding of the Act's requirement of a functional assessment for all claimants who have an unlisted impairment or a combination of impairments. It was this earlier policy that Congress had before it when it enacted the law requiring the Secretary to publish his children's disability

¹² SSR 83-19 also governs Title II eligibility determinations for widows, widowers and surviving divorced spouses. In *Marcus v. Bowen*, 696 F. Supp. at 379-80, the court held that these "spousal" claimants, as well as children claimants, were statutorily entitled to have their eligibility for disability benefits determined by individualized functional assessments of their impairments. Even if this Court rules against the children respondents here, however, the claims of these spousal claimants may survive. At least this is so to the extent that the Court predicates any such (adverse) ruling on statutory language that applies to children but not Title II spousal claimants.

policies, including the listing of impairments, in 1976. Unemployment Compensation Amendments of 1976, Pub. L. No. 94-566, § 501(b), 90 Stat. 2667, 2685 (1976). If Congress can be said to have ratified anything by that law, as the Secretary vigorously argues, it was that earlier policy.

In sum, far from adopting his current policy contemporaneously with the Act and following it consistently since, the policy the Secretary announced at the inception of the Act—and pursued for at least six and one-half years thereafter—was very nearly the opposite of the one he now defends before this Court. The policy he now defends therefore does not reflect either a contemporaneous construction of the Act or a long standing administrative practice, and it is not entitled to deference.

CONCLUSION

The judgment of the court of appeals should be affirmed.

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In the Supreme Court

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JOSEPH F. SPANIOLO, JR.
CLERK**OF THE
United States**

OCTOBER TERM, 1989

LOUIS W. SULLIVAN, Secretary of Health and
Human Services,
Petitioner,

VS.

BRIAN ZEBLEY, et al.,
Respondent.

**On Writ of Certiorari to the United States Court of Appeals
For the Third Circuit**

**BRIEF OF AMICI CURIAE
THE CHILDREN'S DEFENSE FUND
THE CYSTIC FIBROSIS FOUNDATION
THE SPINA BIFIDA ASSOCIATION OF
GREATER LOS ANGELES
THE TOURETTE SYNDROME ASSOCIATION
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In The
Supreme Court of the United States
October Term, 1989

Louis W. Sullivan, Secretary of Health
and Human Services, Petitioner,
v.
Brian Zebley, et. al., Respondent.

On Writ of Certiorari to the
United States Court of Appeals
For the Third Circuit

BRIEF OF AMICI CURIAE
CHILDREN'S DEFENSE FUND, ET. AL.

INTEREST OF AMICI CURIAE
THE CHILDREN'S DEFENSE FUND ("CDF") is a
national public charity representing and

providing advocacy on behalf of America's children, especially low-income, minority, and handicapped children. CDF works through litigation, public education, analysis of public policy, lobbying, and other methods to improve the care and development of children and the economic status of children and their families. CDF's experience in such work demonstrates that children with handicaps have special needs which must be met through public income support programs when family resources are inadequate and that the wrongful denial of such public assistance has a host of adverse consequences for disabled children.

THE CYSTIC FIBROSIS FOUNDATION is striving to provide a better future for people with cystic fibrosis through improved medical care and better research. Cystic fibrosis is a fatal, genetic disease. The symptoms of this disease include thick, sticky, mucus secretions that clog the lungs

and gastrointestinal system, impairing breathing and digestion. The mucus can lead to recurrent lung infections and malnutrition. Other severe complications of cystic fibrosis can include diabetes and cardiac problems. Separately, these symptoms may not meet the Social Security Administration's requirements for disability. However, when all aspects of the disease are viewed together, the combination can be extremely disabling. Currently, many children with cystic fibrosis who apply for Supplemental Security Income (SSI) are turned down because they do not meet the restrictive medical listings. Despite the devastating effect of cystic fibrosis on a child's daily life and the continuous medical treatment that may be necessary, children are ineligible for SSI benefits if their breathing impairments are not severe enough to render them totally disabled according to the respiratory

category in the Listing of Impairments. Often, the effects of the disease on other parts of the child's body are not considered, since the child's total functional capacity is not evaluated.

SKIP (Sick Kids need Involved People) NATIONAL, INC. was organized by parents in 1983 to assist individuals, especially children with their families, who have extraordinary health care needs. Through the national organization and 24 State Chapters, SKIP has touched the lives of several thousand individuals and their families. The diagnoses of these individuals varies widely, but most require life support equipment. One of the goals of SKIP is to advocate for families to receive adequate and appropriate care and services in home and community based environments.

THE SPINA BIFIDA ASSOCIATION OF GREATER LOS ANGELES includes persons with spina bifida, families of children with spina

bifida, and professionals. A significant segment of the membership includes low-income families of children with spina bifida. Many of the disability problems children with spina bifida have, and which result in functional limitations, are not catalogued in the Listing of Impairments. Unlisted factors include: gastrostomy tubes into the stomach through which a child is fed; tracheostomies which are openings into the neck through which the child breathes and through which the child is suctioned to prevent aspiration or pneumonia; and shunts to remove excess fluid from the head to prevent or minimize brain damage from the pressure of water on the brain. Because these functional limitations are not catalogued in the listings, some severely disabled children with spina bifida have not been able to qualify for SSI.

THE TOURETTE SYNDROME ASSOCIATION, INC. is the only national voluntary non-profit

membership organization dedicated to identifying the cause, finding the cure, and controlling the effects of Tourette syndrome. Tourette syndrome is a neurological disorder characterized by involuntary tics -- rapid, sudden movements that occur repeatedly in the same way. Tourette syndrome is a chronic disorder with manifestations that can prevent an individual from functioning independently and that can cause a diagnosed individual to require extended, individualized services. Nevertheless, it is not included in the Listing of Impairments established by the Social Security Administration. Youngsters with Tourette syndrome who have a high level of motor tics can experience significant impairment of their motor function that can interfere with their use of fingers, hands and arms. Drugs that are used to bring the motor symptoms under control can cause lethargy and mental dullness. The socially

unacceptable nature of certain vocal tics has precluded some children from being enrolled in standard classrooms. These symptoms, together with learning disabilities and attention deficit disorder, limit the training of these youngsters for eventual economic self-sufficiency.

THE REHABILITATION PRESIDENTS COUNCIL OF CALIFORNIA (RPCC) is a statewide consortium of professional rehabilitation associations which seeks to improve the effectiveness of rehabilitation through education and research. RPCC represents approximately 2,000 rehabilitation professionals who provide or coordinate physical and vocational rehabilitation services in California.

The following children have been denied SSI on the basis of disability. Their cases illustrate that the Secretary's procedure for determining disability in children's cases fails to take into account significant

functional impairments.

PERLA ACOSTA is two years old and lives in California. She has Down syndrome and is severely developmentally delayed. She functions in the nine to ten month level in speech and communication skills and at the fifteen to eighteen month level in other areas. Her school reports that, because of her severe delay in the area of communication, Perla can be expected to demonstrate a verbal IQ of 59 or below when she is old enough to test.

Perla has been denied SSI on the basis that she has not demonstrated a 50% delay in all areas of development as required by 20 C.F.R. Part 404, Subpart P, Appendix 1 ("Listings") §112.05A. (Determination dated January 26, 1989). Her request for reconsideration is pending.

KENYADA ALES is almost two years old and lives in Mississippi. She was born with severe hydrocephalus which occurs when

cerebrospinal fluid can't exit the brain. In Kenyada's case, a shunt was implanted to enable the excess fluid to drain from her head into her abdomen. In her first 15 months of life, Kenyada suffered three shunt failures which required hospitalization and surgical intervention. Kenyada shows signs of brain damage including developmental delays, hemiplegia, and vision problems, as well as symptoms associated with shunt problems including headaches, nonresponsiveness, and abdominal tenderness.

Kenyada has been denied SSI benefits. An Administrative Law Judge determined that her impairments do not meet or equal the childhood listings (Decision dated May 11, 1989).¹ Her case is pending before the Appeals Council.

DAWN BOUCHER is nineteen years old and

¹ All records and documents referred to are in the custody of the Secretary and have been made available to counsel for the plaintiff-respondents.

lives in Vermont. She reached majority during the time that her claim was on appeal. Therefore she is claiming child benefits for the period before she reached her eighteenth birthday and adult benefits for the period thereafter. Ms. Boucher suffers from borderline retardation but her adaptive functioning is consistent with the mild range of mental retardation. She also has learning impairments, a speech impairment, a mixed personality disorder with dependent and avoidant features, and an anxiety disorder. In addition, she suffers from depression, allergic rhinitis, headaches, and fainting spells.

The federal district court has denied Ms. Boucher's claim for child benefits but has remanded her claim for adult benefits to determine whether she can perform work that exists in the national economy. Boucher v. Bowen, No. 87-183 (D. Vermont Order dated July 20, 1988.) The court denied the claim

for child benefits on the basis that her impairments do not meet or equal the Listing of Impairments. Under current regulations, Listings, §112.05C, her adaptive functioning level and her other impairments cannot be considered because her IQ score is above 69. Boucher v. Bowen, supra, Magistrate's Report and Recommendation (June 9, 1988).

CHERYL CAUDILL is fourteen years old and lives in Kentucky. She was diagnosed as diabetic in February, 1988. Over the following year she was hospitalized several times with uncontrolled diabetes. Her hospital stays ranged from a few days to a week or more. Even when she was in the hospital, the insulin therapy was inadequate to control the diabetes. She also experienced seizure-like symptoms and emotional problems. Cheryl has been denied SSI benefits and now has an appeal pending in federal court. Caudill v. Sullivan No. 89-180 (E.D. Ky. filed July 14, 1989).

SARA CHASE is four years old and lives in Vermont. She was born with Hirschsprung's Disease, a congenital abnormality of the large bowel. By the age of three and one half months, Sara had been through two major surgeries. Since that time, she has had worsening problems of entero colitis, granuloma, severe cramping, malabsorption syndrome, and dysmotility disorder. She also experiences problems of fecal incontinence, abdominal distention, intermittent diarrhea, intermittent rectal bleeding, fissures, eating difficulties, appetite loss, and weight loss. In 1988 alone, Sara was hospitalized five times. In March of 1988, she was started on an enteral feed system by means of a naso-gastric feed tube. The feed tube must be in place 24 hours a day and is hooked up to an infusion pump at least three times.

Sara has been denied SSI twice on initial application. She is now pursuing

her case through the administrative process.

JENNIFER COX is six years old and lives in Iowa. Jennifer suffers from anorectal atresia, a congenital anomaly of the bowe', which required her to have a colostomy. Additional surgery resulted in relocation of the anus and closure of the colostomy. However, she has continuing difficulty with constipation and bowel dysfunction, and further surgery has been recommended. She currently requires daily enemas, suppositories, and adherence to a strict diet to enable her to have bowel movements. In addition, Jennifer suffers from chronic urinary tract infections and is unable to sense when her bladder is full. As a result of these problems, Jennifer is not yet toilet trained. She also suffers from Duane's syndrome, an eye muscle deficiency, which prevents her from moving her eyes to look to either side. As a result, she lacks peripheral vision. Her mother reports that

she must constantly lean sideways to see and that she runs into walls because she cannot see them.

Jennifer has been denied SSI benefits. An Administrative Law Judge determined that her impairments did not meet or equal the listings. He said that her case must be judged solely on the objective medical evidence and not on other factors, which are applicable only to adult determinations. (Decision dated December 28, 1988.)

BLAKE DEWITT is 13 years old and lives in Texas. Blake suffers from asthma, obesity, and childhood migraine. In 1981, after he began taking Prednisone, a cortisone-like anti-inflammatory medication, he began to gain weight very quickly. In 1986, his physician concluded that he was unable to engage in any strenuous activity because of congenital tracheal malasia and acute asthmatic bronchitis with chronic lung disease. Blake's blood pressure has risen

as high as 190/110, and he has suffered severe headaches, vertigo, hypertensive encephalopathy, and nose bleeds. Blake has continued to gain weight, and at the time of his hearing before an Administrative Law Judge, at age eleven, he weighed 241 pounds.

Blake was found to be disabled from June 13, 1978 through December, 1982 but has been denied SSI benefits on reapplication for benefits filed January 1, 1984. His appeal is pending in the Court of Appeals for the Fifth Circuit, DeWitt v. Sullivan, Case No. 89-5559.

RICHARD DOONE is seven years old and lives in Pennsylvania. Richard suffers from asthma, which was diagnosed in 1984. By the time his case was submitted to the Appeals Council in 1988, Richard had been hospitalized six times and had received emergency room treatment twenty times. He has been using a breathing machine for several years, and at the time of his

hearing, he was using it four times a day for one half hour each time. He is taking Slobid, Alupent, and Predatson, and has required parenteral² medication during his asthma attacks. Richard missed 67 days of his eight month preschool program during the 1986-1987 school year, and 21 out of 103 class days in kindergarten the next year.

Richard has been denied SSI. A vocational expert concluded that Richard is disabled because of the frequency of his asthma attacks and because he requires home nebulizer treatments to maintain adequate ventilation. However, the Administrative Law Judge determined that Richard did not meet the Listing of Impairments because the rate of hospitalization had decreased recently and because his medical condition between hospitalizations was not sufficiently severe. (Decision dated March

² "Parenteral" refers to medication administered by injection.

23, 1988.) Richard's case is now before the Appeals Council.

YOLANDA DOWDY is thirteen years old and lives in Pennsylvania. Yolanda is in an EMR (Educable Mentally Retarded) class at school. Although her full scale IQ is in the upper range for EMR students, her academic achievement is in the lower range. Her language development and communication skills are extremely deficient. She wets and soils herself during the day at school. At home she is unable to do age appropriate tasks such as doing the dishes and taking out the garbage. She has also exhibited antisocial behavior.

Yolanda has been denied SSI benefits. She is awaiting the outcome of her June 15, 1989 hearing on remand from the Appeals Council.

AMY GIFFORD is eight years old and lives in Vermont. She has a full scale IQ of 71, and she demonstrates significant

delays in visual-motor abilities, visual-perceptual abilities, language skills and articulation. Unlike children with mild retardation who do not have her other problems, Amy needs to be helped with self-care skills, particularly bathing, toileting, and dressing herself. She is unable to match clothing and to consistently brush her hair. Her ability to retain information is limited. She does not understand money and is not able to tell that there are five pennies in a nickel. She is unable to add simple numbers without counting on her fingers.

Amy also has a speech impairment, which, in combination with her memory difficulties make conversation difficult. She has developed some behavior problems, possibly as a result of frustration in communication. School records indicate that she also suffers from hyperactivity and inattention. She finds it difficult to stay

on task, wanders around the room, and becomes easily frustrated with lengthy problems.

Amy has been denied SSI benefits. The initial denial acknowledged that she had learning problems but concluded that her impairments were not severe enough to meet the special medical requirements for child's disability benefits (Determination dated September 19, 1988). Her case is now pending before an Administrative Law Judge.

LAWRENCE GREATHEART is almost eleven years old and lives in New York. Lawrence suffers from a severe form of asthma with numerous allergies. He requires specialized treatments in the form of inhalation therapy, asthma medications taken by mouth and by injection, a special diet, and chest physiotherapy, including chest percussion and postural drainage. He also requires humidification and air conditioning.

Lawrence was hospitalized repeatedly until his mother was able to obtain a nebulizer a few years ago. He is subject to frequent headaches and gastro-intestinal disturbances related to side effects of the medication he receives. Lawrence is unable to tolerate the public transportation system because he reacts to dust, mildew, and dirt with bronchial spasms. He can't tolerate being out in cold or damp weather for extended periods or when the pollen count is high or the air quality is poor without severe respiratory compromise. He has also been diagnosed as emotionally unstable and is undergoing weekly therapy at a mental health clinic. His school attendance is irregular, with excessive absences. He missed 53 days during the last school year. He has a decreased activity tolerance and cannot participate in most typical activities with his peers without allowing for frequent rest periods.

Lawrence and his family are living in a substandard apartment due to lack of funds. They have frequent problems with water leaks and flooding which leads to the growth of mold and mildew. Spores from the mold and mildew have triggered asthmatic reactions in Lawrence.

Lawrence has been denied SSI on initial application and reconsideration because his condition, though severe, is not disabling according to the standards for minor children.

VALERIE HARTWELL just turned 18 and lives in Vermont. She is claiming children's benefits for the period from September, 1985, when she filed her most recent claim, through her eighteenth birthday on June 25, 1989. Valerie was diagnosed as suffering from cystic fibrosis when she was five months old. She is treated with pancrease, a pancreatic supplement, to aid digestion; with a special

diet; and with chest therapy twice a day to expel the mucus that builds up in her lungs. She has had to be hospitalized frequently when her condition deteriorates, primarily due to serious respiratory complications that require parenteral antibiotic treatment. Her hospital stays last from a few days to a week or more. After discharge, she undergoes intravenous therapy at home for another week.

Ms. Hartwell has a chronic cough which causes frequent gagging and vomiting. She is particularly susceptible to colds and bronchial infections and often has to take antibiotics to avoid more serious illnesses. At age eight, she was diagnosed as suffering from asthma and allergies. As a result, she must use an inhaler four to six times a day and must take Prednisone every other day. The asthma has exacerbated the pulmonary problems caused by the cystic fibrosis, and Ms. Hartwell suffers weekly asthma attacks

which often occur at night causing her to lose sleep.

Ms. Hartwell is allergic to many substances including cigarette smoke, dust, mowed grass, strawberries, carrots, and bees. She continues to be treated for pancreatic insufficiency and to suffer gastro-intestinal distress which causes weekly diarrhea, constant gas and bloating, and frequent stomach pains. In addition, scoliosis was diagnosed in 1984. This condition causes back pain and prevents her from lifting heavy objects. She is being treated for the scoliosis with prescribed exercises and with clinical treatments; however, she finds that she cannot do the prescribed exercises consistently due to her asthma and cystic fibrosis. In 1985, diabetes was diagnosed. At the time of her hearing before the Administrative Law Judge, Ms. Hartwell was taking over 40 prescribed medications daily. Although Ms.

Hartwell was granted SSI benefits at an early age, the Secretary terminated her benefits when her condition improved. She was denied benefits twice in 1983 and again in 1985. She appealed the last denial through the administrative process and the federal court. Her claim has now been remanded for further administrative proceedings. Hartwell v. Sullivan, No. 88-74 (D. Vt. Remanded May 4, 1989).

TERRY HOUCK, is fifteen years old and lives in Wisconsin. He suffers from mental retardation, attention deficit disorder, and minimal brain dysfunction. He is taking Ritalin for hyperactivity. In addition, Terry is very aggressive, has difficulty relating to his peer group, and spends much time alone and withdrawn. He attends classes for children with learning disabilities, but finds school to be a struggle. Recently, doctors have determined that Terry suffers from scoliosis, that his

right leg is slightly longer than the left, and that he has pelvic tilt.

Terry has been denied SSI benefits and has exhausted all levels of administrative review. He is the plaintiff in a federal district court action which has been stayed pending the outcome of this case. Houck v. Sullivan, No. 88-C-1225 (E.D. Wisc. Stay entered May 24, 1989).

DELDRIK JACKSON is twelve years old and lives in New York. Deldrick has been diagnosed as severely emotionally disturbed. He has frequent violent outbursts, and has had a long history of serious disciplinary problems at home and at school. He has been physically and verbally aggressive with little provocation and has been placed in increasingly restrictive special education classes at school.

Deldrick has been denied SSI benefits. An Administrative Law Judge determined that his impairments do not meet or equal the

listings. (Decision dated July, 24 1989). At the hearing, the medical advisor agreed that, if Deldrick were an adult, his problems with concentration, persistence, and pace, alone would prevent his employment at any job. However, the Administrative Law Judge found Deldrick ineligible for benefits because the medical findings did not meet the requirements of the listings.

SHAWN KELLER is eleven years old and lives in Pennsylvania. Shawn suffers from attention deficit disorder; with hyperactivity, mental retardation, learning problems, and a slight speech impediment. His intellectual development has been measured within the borderline range, with a Verbal Score of 70, a Performance Score of 77, and a Full Scale Score of 72. Shawn has demonstrated a delay in visual-motor coordination and low psycholinguistic abilities. He attends EMR special education classes, and despite compliance with a

medication regimen, Shawn has periods of increased hyperactivity when his classroom behavior is unacceptable. He has a short attention span, has difficulty in following directions, and requires one-on-one attention to keep on task.

Shawn has been denied SSI benefits. The Administrative Law Judge found that Shawn did not meet the listings because his lowest IQ score (70) was above the level required by the listings (69). Listings, §112.05C. He also found that the attention deficit disorder did not meet the level of severity required by the listings. (Decision dated November 29, 1988.) Shawn's case is appending before the Appeals Council.

HENRY ROSADO is eleven years old and lives in Pennsylvania. His primary language is Spanish. He suffers from mental retardation, although his IQ scores range from 40 to 78 on different tests. He also

has a visual-motor dysfunction, an oppositional disorder, and attention deficit disorder. Henry takes Ritalin to control his hyperactivity but still experiences difficulty in concentrating and in completing tasks in a timely manner. He has little tolerance for frustration, which results in either impulsive behavior or resignation of effort. In addition, Henry has marked difficulty in social functioning both within his family and with peers or teachers.

Henry has been denied SSI benefits. He appealed the initial denial through the administrative process. His case was remanded from the Appeals Council to an Administrative Law Judge who denied benefits again. Citing evidence that Henry's low IQ scores may have been the result of his passive-aggressive attitude and lack of verbal facility in English, the Administrative Law Judge found that Henry's

IQ did not meet the listings criteria. He also found Henry's oppositional disorder not to be severe. (Decision dated March 28, 1989.)

MONISHA SMITH is ten months old and lives in California. She has spina bifida myelomeningocele. She was born with a sac which contained her spinal cord and its enveloping membranes protruding from her spine. This sac was repaired and covered immediately after her birth. A shunt was implanted to drain cerebrospinal fluid from the brain down into the abdominal cavity. She has experienced one shunt failure which required surgery. The spina bifida has resulted in some paralysis which affects her legs so that she is not yet able to crawl. The paralysis has also affected her bowel and bladder, and as a result, Monisha requires digital stool removal and catheterization every two hours.

Monisha is developmentally delayed in

all areas. She receives occupational therapy in her home twice a week, and in the interim, her mother implements an infant stimulation program. In addition, her complex of problems requires visits to doctors at least once a week. Monica's mother, a single parent, has not been able to return to work because of the care that Monica requires.

Monisha has been denied SSI. She does not meet the listings for congenital abnormalities, because spina bifida is compatible with life outside the womb and because she can be expected to function above the two year old level. Listings, §110.08. She does not meet the neurological listings, because her paralysis has not yet interfered with age appropriate activities. Listings, §111.08A. She does not meet the listing for mental disorders because she cannot demonstrate a delay of 50% or more in all areas of development. Listings,

§112.05A.

JEANNETTE TOOMEY is five years old and lives in Pennsylvania. Jeannette suffers from severe hyperactivity, a mild expressive speech delay, and delayed fine motor skills. Although she receives an unusually high dose of Ritalin, she manifests unmanageable, disruptive, impulsive, and hyperactive behavior. In fact, the Administrative Law Judge commented on her uncontrolled behavior on the day of her hearing when she left her chair, climbed under the examining table, moved constantly about the room, and set off a fire alarm. Nevertheless, Jeannette has been denied SSI benefits. The Administrative Law Judge found clear evidence that she suffers from psychological impairments and behavior problems, but he concluded that these impairments did not satisfy the criteria of the listings. (Decision dated February 15, 1989.)

KENDRA WHALON is two years old and

lives in Texas. She suffers from Klippel-Trenaunay-Weber syndrome, a rare condition that produces a crippling growth disturbance on her left side. Her left arm is now twice the size of her right arm and colored with a birthmark-like stain. When she was 13 months old, her treating physician concluded that the condition will worsen with time, causing functional motor impairment, reduction in mobility and possible respiratory difficulties. At that point, the impairment had caused spinal curvature and loss of lung volume. In 1988, a consulting neurologist noted that Kendra was not able to use her arm at all before she started to receive physical therapy. He concluded that Kendra's overall prognosis is not good because the arm will keep growing enormously in size. He also indicated that surgery may be necessary in the future.

Kendra has been denied SSI benefits, and her case is now pending at the Appeals

Council. In denying her initial claim, the evaluator noted that Kendra may need special care and continued doctor's treatment but concluded that she was still too young to evaluate developmentally. (Determination dated December 14, 1987.) The Administrative Law Judge also found no doubt that Kendra will need regular medical care but concluded that because of the lack of findings at the listings level, he could not make a finding that she was disabled. (Decision dated November 29, 1988).

SUMMARY OF ARGUMENT

Congress extended SSI benefits to children in 1974 in order to provide a greater level of support to those in the greatest need - children with disabilities who live in poverty. Since that time, SSI has been an essential source of support for many children with disabilities and their families. However, not all children with seriously disabling conditions have been able to benefit from this program.

In this case, the Court of Appeals held that the Secretary's procedure for determining disability in children's cases violates the Social Security Act because it does not permit children to show that they suffer from any disability of comparable severity to one that would qualify an adult for SSI benefits. The Secretary's procedure is deficient because it does not provide children with the opportunity, which the Secretary provides to adults, to demonstrate

the impact that their impairments have on their ability to function.

The cases described by Amici illustrate how this limited procedure ignores seriously disabling impairments. The Secretary's procedure requires children to show medical impairments that meet or are equal to the Listing of Impairments developed by the Secretary. The procedure does not consider the actual effect the impairments have on individual children. Furthermore, it disregards significant disability factors such as dependence on medical technology or absence from school and fails to consider the actual degree of support a child may require.

Improving the Listing of Impairments will not fully resolve these problems because no medical listing can incorporate individual differences in each child's actual ability to function.

ARGUMENT

I. THE SSI PROGRAM PROVIDES ESSENTIAL SUPPORT TO CHILDREN WITH SPECIAL NEEDS.

In 1974 Congress extended the benefits of the SSI program to children to provide a greater level of support than was available at that time to children in the Aid to Families with Dependent Children (AFDC) program. The report issued by the House Committee on Ways and Means says:

It is your committee's belief that disabled children who live in low-income households are certainly among the most disadvantaged of all Americans and that they are deserving of special assistance in order to help them become self-supporting members of our society.

Making it possible for disabled children to get benefits under this program, if it is to their advantage, rather than under the programs for families with children, would be appropriate because their needs are often greater than those of non-disabled children.

House Report No. 92-231, 92d Cong., 2d Sess., pp. 147-8, reprinted in 1972 U.S. Code Cong. & Adm. News 4989, 5133-34.

Since that time, the SSI program has been an essential source of support to many children with disabilities and their families. A study commissioned by the Secretary concluded that the benefits available through the SSI program are important in meeting the significant costs of caring for a child with disabilities. Urban Systems Research & Engineering, Inc., Survey of Blind and Disabled Children Receiving Supplemental Security Income Benefits, SSA Publication No. 13-11728, 65-67 (1980). ("Survey"). In many cases, the SSI program is the only source of support for children with disabilities because it provides benefits to children in intact families who would not have been eligible for AFDC.³ Id. Even for children who are

³ In order to be eligible for AFDC, children must be deprived of parental support and care because of the death, continued absence, incapacity, or, in some states, unemployment of a parent. 42 U.S.C. §606 (a). Because "unemployment" is defined

eligible for AFDC, the higher SSI benefits are important in meeting out-of-pocket costs and the medical expenses not covered by the medicaid program. Id. 63-64.

The high cost of caring for a child with disabilities has been confirmed by other researchers. See, e.g., J. Butler, P. Buddetti, M. McManus, S. Stenmark, P. Newacheck, Health Care Expenditures for Children with Chronic Illness, in ISSUES IN THE CARE OF CHILDREN WITH CHRONIC ILLNESS, 827 - 863 (N. Hobbs, J. Perrin, eds. 1985). In the case of children with spina bifida, out-of-pocket expenses directly attributed to the child's condition have been estimated to average 12.3 percent of family income. Id. at 876. Children with cystic fibrosis often require nonprescription medications, physical therapy, extra food and nutritional

stringently, many children in intact families are not eligible for AFDC even if neither parent is employed.

supplements, and equipment for lung care, such as nebulizers, and mechanical chest percussors. N. Lewiston, Cystic Fibrosis, in ISSUES IN THE CARE OF CHILDREN WITH CHRONIC ILLNESS, supra, 201-203. Children with diabetes need more expensive food to meet special dietary needs. Children with certain mental impairments and those who are dependent on medical technology need constant or frequent protective supervision and monitoring. In many families, the parents' ability to work is limited because of the extraordinary time demands involved in providing supervision or special treatment. See e.g., D. Salkever, Parental Opportunity Costs and Other Economic Costs of Children's Conditions, in ISSUES IN THE CARE OF CHILDREN WITH CHRONIC ILLNESS, supra. 864-879. Even the expense of transportation to and from the hospital and the offices of various doctors and therapists becomes significant to families

with limited financial resources. Furthermore, many medical insurance programs require families to make co-payments for out patient services and drugs.

Children with disabilities are also more likely to be harmed by poor living conditions than are children without impairments. Substandard housing, lack of heat, inadequate nutrition, and other effects of poverty often have a serious effect on already vulnerable children. Furthermore, utility services may be critical to children with special needs. For example, the need for a regulated temperature or for special equipment not only makes utility service essential but also results in high utility bills.

In addition to the cash SSI provides to many low income children and their families, SSI eligibility may be necessary to

establish eligibility for medicaid,⁴ home health services, and other supportive programs in many states. Thus, SSI is essential to meet the special needs of children with disabilities who live in low income households. However, many needy children with severe impairments are denied the benefits of SSI.

II. THE SECRETARY'S METHODOLOGY FOR DETERMINING DISABILITY IN CHILDREN'S CASES IS UNDULY RESTRICTIVE IN THAT IT EXCLUDES CHILDREN WITH SERIOUS DISABLING IMPAIRMENTS WITHOUT PROVIDING THEM AN OPPORTUNITY TO DEMONSTRATE THEIR ACTUAL DEGREE OF FUNCTIONAL LIMITATION.

SSI benefits are available to adults and children who meet the SSI financial criteria and who are disabled. 42 U.S.C. §1381. An adult is disabled if he or she

is unable to engage in any substantial gainful activity by reason of any medically determinable physical or

⁴ States must provide medicaid benefits to children who are on SSI, 42 U.S.C. §1396a(a)(10)(A)(i), but have the option of providing these benefits to many other needy children. 42 U.S.C. § 1396a(a)(10)(A)(ii).

mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

42 U.S.C. §1382c(a)(3)(A). Children are disabled if they suffer "from any medically determinable physical or mental impairment of comparable severity." Id.

The Court of Appeals for the Third Circuit held that the Secretary's procedure denies children the opportunity to show that they suffer from any impairment of comparable severity to an impairment that would be considered disabling in an adult. Zebley v. Bowen, 855 F. 2d 67 (3rd Cir. 1988). The inquiry for children is limited to whether there are medical findings establishing an impairment that meets or is equivalent to the Listing of Impairments developed by the Secretary. Id. 74. Adults who do not meet this listings requirement are permitted to demonstrate that they are, nevertheless, disabled based on their actual

degree of functional impairment. Id. 73 Children are denied this opportunity to prove disability. Therefore, the Court of Appeals held, the Secretary's regulations are inconsistent with the statute "in precluding a finding that a child is disabled unless his impairment meets or equals a listed one." Id., 73-74.

The experience of Amici illustrates the effect of the Secretary's failure to consider a child's actual degree of functional impairment. Many children who should be found eligible are excluded from the SSI program because their particular impairment or combination of impairments do not mesh with the listings.

A. The Secretary's Procedure Fails to Take Into Account Significant Disabling Conditions.

The Listing of Impairments does not include factors that are common to many impairments, such as pain, reduced stamina, and the side effects of medication. In

adults, these factors are considered in making the assessment of residual functional capacity. However, that consideration is denied to children.⁵ Therefore, factors such as the pain caused by Blake DeWitt's migraine headaches, the discomfort resulting from Valerie Hartwell's gastro-intestinal problems, and the lack of stamina suffered by Blake and by Lawrence Greatheart is ignored.

Moreover, the Listing of Impairments does not address the symptoms that accompany many conditions, such as Tourette syndrome, attention deficit disorder, Down syndrome, or cystic fibrosis,⁶ even though these conditions require intensive support and

⁵ Congress underscored the importance of an individualized assessment of pain in enacting the Disability Amendments of 1984, Pub. L. 98-240, 42 U.S.C. § 1382c(a)(3)(g), incorporating §423(d)(5)(A).

⁶ The listings for cystic fibrosis cover only the respiratory symptoms. See, Listings, §103B.

intervention. As a result, children with these conditions must demonstrate that their impairments are equivalent to a listed impairment. However, the Secretary's definition of medical equivalence is extremely restrictive. Social Security Ruling (SSR) 83-19, J.A., 236, 238-240; Social Security Administration (SSA), Policy Operations Manual System (POMS), §24505.015, J.A. 244, 246-251. It expressly precludes any consideration of an actual functional limitation, SSR 83-19, supra, 239-240; POMS, supra, 251.

Lawrence Greatheart's case demonstrates the problems with the Secretary's methodology. The listings do not include allergies and do not provide a means for considering the functional impact of Lawrence's allergies. Therefore, the decisionmakers cannot take into account that Lawrence's allergies preclude him from using public transportation and prevent him from

going outside on many days. The effect of his medications and of his emotional problems are also disregarded. Valerie Hartwell's allergies and her susceptibility to bronchial infections are also excluded from consideration. Kendra Whalon's rare condition is not close enough to any of the listings to permit an adequate comparison.

Blake DeWitt's case demonstrates the inflexibility of the Secretary's procedure. Blake was denied benefits because he was unable to show that his hypertension caused impaired renal functioning, cerebrovascular damage or congestive heart failure, Listings §104.03, even though it frequently exceeded the level established by the child listings. His frequent headaches, dizzy spells, and nosebleeds are not taken into account to determine whether the combination of these impairments equal the listings. Blake is further disadvantaged by the fact that there is no childhood listing for obesity. The

Administrative Law Judge was required to use the adult listing for obesity which is clearly inappropriate because a child's bone structure is different from the bone structure of an adult. Blake was not found to be obese, even though his height, at 64 1/2 inches tall, was slightly below that of an average eleven year old but his weight, at 241 pounds, was more than three and a half times that of an average eleven year old at the time of his hearing.

Jeannette Toomey's case provides another illustration. Despite clear documentary evidence, supported by observations at the hearing, that Jeannette's behavior was out of control, the Administrative Law Judge felt constrained to deny benefits. As the medical advisor commented in his testimony, Jeannette's condition falls "through the cracks" in the listings. Toomey Decision, supra, 4.

Children with retardation are

particularly susceptible to falling through the cracks. When retardation is accompanied by another impairment, the additional impairments are not considered in combination unless the child's IQ score falls below 69, regardless of ability to function. Listings, §112.05C. For example, Yolanda Dowdy's severe cognitive impairments were not considered because her IQ scores fell above 69, even though her functioning, in the lower end of the EMR range, would equate to an IQ substantially below 69. Thus, Yolanda had to show that she had impairments, other than her cognitive impairments, that met or equaled a listing.

The cases of Amy Gifford, Terry Houck, Shawn Keller, and Henry Rosado present similar problems. Because their IQ scores were above 69, the impact of their impairments on their actual ability to function is irrelevant. Amy's learning disabilities reduce her ability to function

to a level well below that of a child with mild retardation alone. Terry's behavior and attention problems also reduce his ability to function. However, the IQ scores of these children prevent consideration of the overall effect of all of their impairments. In Shawn's case, the medical advisor agreed that the one point difference between Shawn's lowest score (70) and the listing requirement (69) was not meaningful, but Shawn was found not to meet the listings nevertheless. Therefore the combination of his impairments were not considered. In Henry's case, his behavioral problems and his limited knowledge of English were used to discount the IQ scores that fell below 69, rather than as evidence of impaired functioning.

Ms. Boucher's case demonstrates the difference between the treatment of children and adults. She was found not to meet the listings as a child because her IQ scores

were above 69, but as an adult, she is entitled to an assessment of her ability to do work in the national economy. This assessment will take into account the fact that she functions at a lower intellectual level than she tests.

Very young children cannot be tested for IQ. As a result, they must show a 50% delay in all areas of development. Listings, §112.05A. However, this measurement imposes an even more stringent test than does the IQ requirement. The requirement of a 50% delay is analogous to requiring a 50 IQ in mental functioning. Older children need only show an IQ score at or below 59 to qualify. In addition, older children with an IQ score between 60 and 69 may qualify by showing an additional mental or physical impairment. However, young children must show a 50% delay in all areas. Perla Acosta's case illustrates the harshness of this limitation. Even though

her developmental delay is clearly severe, she will not be able to demonstrate that she meets the listings until she is older. Monisha Smith has also been unable to demonstrate a 50% delay in all areas, despite the obvious severity of her impairments.

B. The Secretary's Procedure Fails to Take Into Account Significant Disabling Factors.

The listings do not take into account such things as dependence on medical technology, degree of support required, and absence from school. Consequently, these factors are not considered in making disability determinations for children.

Advances in medical technology have saved the lives of many children and allow many children who were once confined to institutional settings to live at home. Office of Technology Assessment Task Force, TECHNOLOGY-DEPENDENT CHILDREN: HOSPITAL VS. HOME CARE, 5 (1988), and Newacheck, Fox, &

McManus, Home Care Needs of Chronically Ill Children, CARING, (June, 1988). However, the Secretary does not take into consideration a child's dependence on this technology when determining disability.

For example, the listings do not consider tracheostomies. Tracheostomies are surgical openings in the neck through which a child breathes and through which liquids are suctioned (extracted) to prevent aspiration or formation of mucous plugs which could cut off breathing.⁷ Tracheostomies impose significant limitations on the activities of daily living, and a child with a tracheostomy usually requires supportive help at home.⁸

⁷ The frequency of the need for suctioning varies from as often as every five to ten minutes to once every other hour.

⁸ Having a tracheostomy is one of the indices of a need for skilled nursing care. 42 C.F.R. §409.33(b)(3). See, also, 42 C.F.R. §440.170 (d) incorporating §440.40 and §§409.31 through 409.35.

Most children with tracheostomies have to be closely monitored to identify the need for intervention. They also usually require pulmonary toileting.⁹ Because a child with a tracheostomy does not have the advantage of a nose to moisten air and trap dust, there are environmental limitations on where the child can go and what he can do.

The listings also do not include a range of feeding problems children experience. Because of problems in swallowing, problems with esophagus peristalsis, and problems with reflux and the aspiration of food and fluids into the lungs, many children require specialized assistance in order to receive nutrition.

⁹ Pulmonary toileting is a procedure which involves placing the child in a downward slant and percussing each of the eight lung lobes to loosen secretions. The need for pulmonary toileting varies from once or twice a day to every three hours. Failure to provide proper pulmonary toileting and timely suctioning can result in aspiration pneumonia.

This assistance may take the form of a gastrostomy (where a tube is surgically implanted in the stomach), a nasal-gastric tube, or a specific feeding protocol.¹⁰ Feeding with a nasal-gastric tube, such as that required by Sara Chase, requires the insertion of a tube through the nose, down the throat, and into the stomach. This creates a need for extensive support and presents obvious functional limitations.¹¹ Even greater than the number of children who are dependent on medical technology, is the number of children who require extensive

¹⁰ Children who require specific feeding protocols have to be fed slowly and carefully over a period of time, often taking an hour and a half or more per feeding. After feeding, they typically have to be positioned correctly to minimize the risk of food refluxing from the stomach up into the lungs.

¹¹ Having a gastrostomy or needing a nasal-gastric tube for feeding is also one of the indices of the need for skilled nursing care. 42 C.F.R. §409.33(b)(2). See note 8 above.

care at home. Newacheck, Fox, & McManus, supra. One study found that among children with significant functional limitations, help from another person was the most common type of assistance required, Id., 8. However, the Secretary does not take the need for such support into consideration in making disability determinations for children.

For example, the shunts required by Kenyada Ales and Monisha Smith impose extra care responsibilities on the family, including daily measurements of the head, monitoring of temperature to detect a shunt infection, and monitoring for nausea and changes in behavior, which indicate a shunt failure. Monisha's mother also provides daily infant stimulation therapy. Valerie Hartwell requires extensive support to provide chest therapy, to perform pinprick blood tests for diabetes four times a day, to administer insulin injections twice

daily, to administer 40 types of medication daily, to adjust her diet, and to monitor her for signs and symptoms that indicate the need for medical intervention. Jennifer Cox's mother must manage Jennifer's diet, administer daily enemas, monitor Jennifer's bladder activity closely to avoid infection, and change her several times a day because of Jennifer's inability to regulate her bladder and bowels. However, the need for extensive support is not considered in determining whether these children are entitled to receive SSI.

Some children require considerable supervision because of their behavior. For example, Jeannette Toomey and Deldrick Jackson need close supervision to attend to school work or to avoid getting into difficulty. However, this need for supervision is not part of the disability determination.

Neither is frequent hospitalization

considered, even when it significantly interferes with school. For example, Sara Chase was hospitalized five times in 1988, and Kenyada Ales has been hospitalized for surgery three times in the 22 months she has been alive. Richard Doone and Cheryl Caudill missed a significant amount of school as a result of hospitalization and other medical intervention. However, these factors are not taken into account. Richard Doone's need for four to six half hour treatments every day is also ignored.

These examples illustrate the problems that result from the Secretary's requirement that children meet or equal the Listing of Impairments. The Secretary has recently made an effort to improve the listings, but even improved listings will not compensate for the failure to provide children with an opportunity to prove their actual degree of functional limitation.

C. Improvement of the Listing of Impairments Will Not Provide Children With an Adequate Opportunity to Demonstrate Disability.

The Secretary has proposed regulations that would substantially revise the Listing of Impairments for Mental Disorders. 54 Fed. Reg. 33,238 (August 14, 1989). These regulations, if promulgated, will improve the Secretary's determination process for children with mental disorders. This improvement is important because the listings permit preliminary screening without the need for a full individualized assessment in the case of individuals whose impairments meet or equal the listings. Bowen v. City of New York, 476 U.S. 467, 470 (1986); Bowen v. Yuckert, ____ U.S. ____, 107 U.S. 2287, 2297 (1987). However, the proposed regulations do not address problems with the listings for physical impairments. Furthermore, even improved listings will not fully address the need for an individualized

assessment of functioning. See, Mental Health Association of Minnesota v. Schweiker, 554 F. Supp. 157, aff'd, 720 F. 2d 965 (8th Cir. 1983); Bowen v. City of New York, supra.

As the Secretary has recognized "[n]ot all children's impairments will lend themselves to formal codification." SSI Disability Insurance Letter No. III-11, Supp. 1 (January 9, 1974), J.A., 97. Furthermore, new and unforeseen problems,¹² developments in medicine, and differences in medical judgment will continue to make any set of medical listings inadequate as the sole criterion for determining disability.¹³ More importantly, even the most thorough

¹² For example, we are just beginning to appreciate the magnitude of the problems caused by prenatal drug exposure.

¹³ The Secretary explicitly recognized these problems in his discussion of behavioral and learning disorders. SSA Disability Insurance Letter No. III-11-Supplement 1, supra, J.A., 97-98.

listing of medical impairments⁷ will not provide an individualized assessment that considers how each child's impairments interfere with age appropriate activities of daily living, including the amount of support and intervention the child requires in order to perform those activities.

Thus, no rigid listing of medical impairments can replace the individualized assessment of a child's ability to function. Rather, the Secretary must give children the same opportunity to prove the existence of a disabling impairment that he provides to adults.

CONCLUSION

The foregoing demonstrates that the Court of Appeals was correct in holding that the Secretary's procedure denies children the opportunity to prove that they suffer from an impairment that is of comparable severity to an impairment that would be found to be disabling in an adult. This Court should uphold the decision of the Court of Appeals for the Third Circuit in this case.

Respectfully
Submitted,

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